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State College, PA 16801

WELCOME TO OUR OFFICE

Patient Information:

Patient Name: _____
Street Address _____
City/State _____ zip code _____
Home Phone _____ work phone _____ cell phone _____
Date of Birth ____ / ____ / ____ Soc. Sec. # _____

Employer _____ Address _____
City/State _____ zip code _____

If patient is a full-time student, name of school _____

In case of an emergency, who should be notified? _____
Phone _____ Relationship to patient _____

Who may we thank for referring you? _____

Dental Insurance Information: (Primary)

Policy Holder _____
Relationship to Patient _____ Date of Birth ____ / ____ / ____
Address (if different than patient) _____
City/State _____ zip code _____

Policy Holder employed by _____
Address _____
City/State _____ zip code _____
Soc. Sec. # _____ Work Phone _____

Insurance Company _____ Group # _____
Insurance Company Address _____
City/State _____ zip code _____
Phone _____

continued . . .

Dental Insurance Information: (Secondary)

Is patient covered by additional insurance? ___Yes ___No

Policy Holder_____

Relationship to patient_____Date of Birth____/____/____

Address (if different than patient)_____

City/State_____Zip Code_____

Policy Holder Employed by_____

Address_____

City/State_____Zip Code_____

Soc. Sec. #_____Work Phone_____

Insurance Company_____Group #_____

Insurance Company Address_____

City/State_____Zip Code_____

Phone_____