Account & Insurance Information

Patient's Name (s):____ Today's Date: _____________

Responsible Party

Name:____ Birth date:____________________________

Relation:____ SS#:____

Billing Address:____

City:____ State:_____________________ Zip:__________________________

Primary Phone: ______________________ Secondary Phone: _______________________ Email: _______________________

Employer:____ Work Phone: ___________________________________

Primary Dental Insurance

Policy Holder:_____________________________________

Relation:____

Address:____

City:________________State:________ Zip:____________

Home #: (   ) ____________________________________

SS#:__________________DOB:______________________

Employer:____

Insurance Company:_______________________________

Insurance Company Address:________________________

City:__________________ State:_________ Zip:_________

ID#:____

Group #:____

Secondary Dental Insurance

Policy Holder:_____________________________________

Relation:____

Address:____

City:________________State:________ Zip:____________

Home #: (   ) ____________________________________

SS#:__________________DOB:______________________

Employer:____

Insurance Company:_______________________________

Insurance Company Address:________________________

City:__________________ State:_________ Zip:_________

ID#:____

Group #:____

Adventure Dental
Pediatric Dentistry and Orthodontics