NEW PATIENT INSURANCE INTAKE FORM

Patient Name: ____

Patient DOB: ____

SSN# of Patient: ____

Dental Insurance Company: ______________________________________

Name of Insured: ____

Address of Insured: ____

DOB of Insured: ____

SSN# of Insured: ____

ID #: ____

Group#: ____

Phone Number of Insurance Company: ______________________________

Primary Account Holder: ____

Insured Employers Address: ______________________________________

Insured Employers Phone Number: __________________________________

Insured Employer: ____

Insured Relationship to Patient: (please circle relationship)

Self Spouse Child Parent