REFERRAL INFORMATION

How did you hear about our office?

- □ Another patient, friend _____
- □ Another patient, relative _____
- □ Another dental office _____
- □ Billboard
- □ Drive By
- □ Insurance
- □ Internet Search
- □ Yellow Pages
- □ Other_____

EMPLOYMENT INFORMATION

Employer Name: _____ Phone #: (_____) _____

Street Address: _____ City, State Zip _____

INSURANCE INFORMATION

Primary

Insurance Carrier: _____

Name of Insured: _____ Is Insured a patient? □ YES □ NO

Insured's Birth Date: _____ / _____ / _____ Group #: _____

Insured's Address (if different from patient)

Street Address: _____ City, State Zip _____

Insured's Social Security #: _____ / _____ / _____ Member ID: _____

Insured's Employer: _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____

Secondary

Insurance Carrier: _____

Name of Insured: _____ Is Insured a patient? □ YES □ NO

Insured's Birth Date: _____ / _____ / _____ Group #: _____

Insured's Address (if different from patient)

Street Address: _____ City, State Zip _____

Insured's Social Security #: _____ / _____ / _____ Member ID: _____

Insured's Employer: _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____

I certify that I have read and understand the above and that the information provided on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information when treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ Date: _____ / _____ / _____

Signature of Patient or Legal Guardian