SYLVAN HEIGHTS
DENTAL

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

PERSONAL

Name_____
First MI Last (Preferred Name)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Address_____

City_____ State_____Zip_____

Cell Phone_____ Home Phone_____

Email_____

Would you like to receive electronic billing statements to your email? [ ] Yes [ ] No
(If not, a paper statement will be sent to your home address)

Preferred contact method [ ] CellPhone [ ] HomePhone [ ] Email

Preferred contact method for confirmations [ ] Phone Call [ ] Text Message [ ] Email

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

Emergency contact _____ Relationship _____

Phone number _____

PRIMARY INSURANCE POLICY

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Group #: _____

Employer: _____ Occupation: _____

Please present insurance card to receptionist.

SECONDARY INSURANCE POLICY

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____