PATIENT NAME: ________________________________ DATE OF BIRTH: ___________

PATIENT ADDRESS: ____

CITY, STATE, ZIP: ____

PRIMARY PHONE: _________________________ WORK PHONE: ____________________

PATIENT SOCIAL SECURITY NUMBER: _____________________ SEX: ___M ___F

EMAIL: ____

____ I WOULD LIKE TO RECEIVE CORRESPONDANCE BY EMAIL

____ I AM ABLE TO ACCEPT TEXT MESSAGES

PHYSICIAN: ____________________________ PHYSICIAN PHONE: ________________

RESPONSIBLE PARTY NAME: __________________________ DATE OF BIRTH:________

RESPONSIBLE PARTY ADDRESS: ____ SAME AS ABOVE (IF DIFFERENT, COMPLETE BELOW)

ADDRESS: ______________________________ CITY, STATE, ZIP: ________________

HOW DID YOU HEAR ABOUT HERRICK AND VERHOFF DENTAL? ____________________

____

PRIMARY INSURANCE INFORMATION:

NAME OF INSURED: ________________________________ DATE OF BIRTH:_________

RELATIONSHIP TO PATIENT: ________________________

NAME OF INSURANCE CARRIER: _____________________ SECONDARY: ____________

NAME OF INSURED EMPLOYER: ____

INSURED SOCIAL SECURITY NUMBER AND/OR MEMBER I.D.: ____________________

** PLEASE PRESENT COPY OF INSURANCE CARD **