

LAUDENBACH DENTAL GROUP

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www.laudenbach.com

PATIENT INFORMATION

NAME: LAST	FIRST	MI	BIRTHDATE	DENTAL #
HOME ADDRESS				CELL PHONE:
CITY	STATE	ZIP	TELEPHONE (HOME):	SOC. SEC. #
EMPLOYER:			PROFESSION:	
WORK ADDRESS:			TELEPHONE (WORK):	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY	STATE	ZIP	EMAIL ADDRESS:	

Person to contact in case of emergency and there relationship to you:

Phone # _____

Who referred you to our practice? _____

Primary Dental Insurance:

Subscriber's Name-	Subscriber's DOB-
Name of Insurance Company-	Subscriber's S.S.#-
Insurance Co. Address-	Group #-
Subscriber's Employer-	Insur. ID #-
Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Insur. Phone #-

Secondary Dental Insurance:

Subscriber's Name-	Subscriber's DOB-
Name of Insurance Company-	Subscriber's S.S. #-
Insurance Co. Address-	Group #-
Subscriber's Employer-	Insur. ID #-
Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Insur. Phone #-

As a point of information, we are not direct participants in dental insurance. We ask that the patient pays the bill as service is rendered. We will submit your information for you at your request, and we do help in maximizing your benefits when appropriate.

