

Patient Name \_\_\_\_\_ Appt. Date \_\_\_\_\_

**Patient Information-**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

E-mail : \_\_\_\_\_ Cell Ph # \_\_\_\_\_

Preferred Method of Contact: 1) \_\_\_\_\_ 2) \_\_\_\_\_

**Primary Insurance Information**

Name of policy holder: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_ Ins.Phone #: \_\_\_\_\_

Ins Address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Secondary Insurance Information**

Name of policy holder: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_ Ins.Phone #: \_\_\_\_\_

**Additional Information:** - family members also are making appointments.

Name of patient:

Date of Birth:

1). \_\_\_\_\_

2). \_\_\_\_\_

3). \_\_\_\_\_

**How did you hear about us?**

- Newspapers                      which one: \_\_\_\_\_
- Referral                          Name of person: \_\_\_\_\_
- Insurance Co.                  Name: \_\_\_\_\_
- Insmile Dentistry website
- Other \_\_\_\_\_ (please be as specific as you can)

