Cantrell DENTAL

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us — we will be happy to help.*

*Date* _____

## *Patient Information* (CONFIDENTIAL)

*Mobile #* _____

*Soc. Sec. #* _____

*Name* _____ *Birthdate* _____ *Home Phone#* _____

*Address* _____ *City* _____ *State* _____ *Zip* _____

*Check Appropriate Box:* ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

☐ *Male* ☐ *Female*

*If Student, Name of School / College* _____ *City* _____ *State* _____ *Zip* _____

*Patient's or Parent's Employer* _____ *Work Phone#* _____

*Business Address* _____ *City* _____ *State* _____ *Zip* _____

*Spouse or Parent's Name* _____ *Employer* _____ *Work Phone* _____

*Whom May We Thank for Referring You?* _____

*Person to Contact in Case of Emergency* _____ *Phone#* _____

*Email Address* _____

## *Insurance Information*

**Co-Pays are collected on the date of service based on an estimate of what insurance will pay.**
**Guarantor is responsible for all treatment not covered by insurance.**

*1. Primary Insurance Company* _____ *Group #* _____ *Policy/ID#* _____

*Subscriber/Policy Holder Name* _____ *DOB* _____ *SSN* _____

*2. Seconary Insurance Company* _____ *Group #* _____ *Policy/ID#* _____

*Subscriber/Policy Holder Name* _____ *DOB* _____ *SSN* _____