

Patient Information

Please Print

Title: _____ Patient First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Social Security # _____ - _____ - _____ Patient Date of Birth: _____ Sex: **M** **F**

Email Address: _____ May we contact you by email? **Yes** **No**

Emergency Contact: _____ Phone: _____

How did you hear about Havasu Dentistry? _____

*If patient is under the age of 18, Parent or Guardian please fill out below:

Parent/Guardian Name _____

Date of Birth: _____ Social Security # _____ - _____ - _____

Insurance Information

Do you have Dental Insurance? **Yes** **No**

Primary Insurance	Secondary Insurance
Subscriber Name: _____	Subscriber Name _____
Subscriber SSN: _____	Subscriber SSN: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber: Self Spouse Child Other	Relationship to Subscriber: Self Spouse Child Other
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone # _____
Insurance Company: _____	Insurance Company: _____
Insurance Group # _____	Insurance Group # _____
Insurance Phone # _____	Insurance Phone # _____
Insurance Address: _____	Insurance Address: _____

Please present insurance card and Drivers License