WELCOME

Preferred Pharmacy & Location:_____

For our patients that carry dental insurance:

Please note: We are happy to assist all of our patients in preparing insurance claims, however payment in full is due at the time of your visit. Please speak with reception if there are any concerns regarding payment or insurance reimbursement.

Employer (if dental insurance is through employer):_____

Employer Address:_____

Employer Phone:_____

Dental Insurance

Primary:_____

Address:_____

ID#:_____ Policy or Group #:_____

Subscriber Name (if other than patient)_____

Subscriber SSN:_____ Subscriber DOB:_____

Secondary:_____

Address:_____

ID#:_____ Policy or Group #:_____

Subscriber Name (if other than patient)_____

Subscriber SSN:_____ Subscriber DOB:_____