

Confidential Patient Information
Prairie Rose Family Dentists – North

PERSONAL INFORMATION

Name _____ Nickname _____

Address _____ City _____ Zip _____

SS # ____ - ____ - ____ Home phone # _____ Cell # _____

Employer _____ Work phone # _____

Birthday _____ Sex ____ Marital Status _____ Spouse Name _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____ SS # ____ - ____ - ____

Address _____ City _____ Zip _____

Birthday _____ Home phone # _____ Cell # _____

Employer _____ Work phone # _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: Name _____

Address _____ Phone # _____

Subscriber _____ Subscriber's Employer _____

Relationship _____ SS # ____ - ____ - ____ Policy # _____

Secondary Insurance Company: Name _____

Address _____ Phone # _____

Subscriber _____ Subscriber's Employer _____

Relationship _____ SS # ____ - ____ - ____ Policy # _____

I understand that payment is my obligation regardless of insurance or other third party involvement.

Signature _____ Date _____