optima
DENTAL CARE

Phone# (208)773-5121 Fax# (208)777-9484
www.optimadentalcare.com

## PATIENT INFORMATION

Patient's Name: _____
Last First MI Preferred Name ❑Male ❑Female

Birthdate: _____/ _____/_____ Age: _____ SS#: _____-_____-_____ ❑Child ❑Single ❑Married ❑Other

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

❑ Home ❑ Cell #: ( )_____-_____ Email: _____
***** TEXT [ Y ] [N]*****

***Who may we thank for referring you to our office? Name: _____***

## EMPLOYMENT

Patient Employer: _____ Occupation: _____

Work Phone#: ( ) _____-_____ Fax# :( )_____-_____

## FAMILY

**❑ Guardian ❑ Parent ❑ Spouse ❑ Emergency Contact (Relationship to Patient): _____**

Name: _____ ❑ Home ❑ Cell #: ( )_____-_____

Birthdate: _____/ _____/_____ SS#: _____-_____-_____ Email: _____

Employer: _____ Work Phone#: ( )_____-_____

## PRIMARY DENTAL INSURANCE

Insurance Company**:** _____ Phone#: ( )_____-_____

Group Name: _____ Group #: _____ ID#: _____

Employer: _____ Phone#: ( )_____-_____

Employee: _____ Birthdate: _____/ _____/_____ SS#: _____-_____-_____

**I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.(Please Initial) _____**

## SECONDARY DENTAL INSURANCE

Insurance Company**:** _____ Phone#: ( )_____-_____

Group Name: _____ Group #: _____ ID#: _____

Employer: _____ Phone#: ( )_____-_____

Employee: _____ Birthdate: _____/ _____/_____ SS#: _____-_____-_____

***I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.(Please Initial) _____***