DOUGLAS DENTAL
& ORTHODONTICS
elevate your smile

Contact & Insurance Information

Patient Name: _____ _____ Age: _____
First Last Nickname

Patient DOB: _____/_____/_____ Patient Phone # (_____)_____

Mailing/Billing Address

_____
Street Address City State Zip

Patient Email _____
*used for appointment reminders and coorespondence

How did you find us: _____ Referred by: _____

Emergency Contact: _____ Relation: _____ Phone: _____
Name

Primary Insurance Holder: _____ or No Insurance
(Subscriber) First Last

Subscriber Relation to Patient _____ Subscriber DOB:

_____/_____/_____

Insurance Carrier _____ Ins. Carrier Phone #: _____

Member ID or SSN of Subscriber _____

Group Name: _____ Group # _____

❑ I, as the patient, have secondary dental coverage

2nd Insurance: _____ Ins Phone # _____

Subscriber Name: _____ Subcriber DOB: _____/_____/_____

Member ID or SSN: _____ Relation to patient: _____

Individual filling out form if not self _____ Relation to pt _____
Name