vh dental

Thank you for trusting your dental health with us! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ BIRTHDATE _____ SS#_____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

CELL PHONE _____ HOME PHONE _____

WORK PHONE _____ EMAIL _____

Who may we thank for referring you? _____

Check Boxes: □ Minor □ College Student □ Single □ Married □ Divorced □ Widowed □ Separated.

PARTY FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (IF DIFFERENT THAN PATIENT)

NAME _____ BIRTHDATE _____ SS#_____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

CELL PHONE _____ HOME PHONE_____ WORK PHONE _____

EMAIL _____ _____ RELATIONSHIP TO PATIENT _____

PRIMARY DENTAL INSURANCE

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

DOB _____ SS# _____ EMPLOYER _____

INSURANCE COMPANY _____ GROUP # _____CONTRACT#_____

INSURANCE COMPANY ADDRESS _____

INSURANCE PHONE NUMBER _____

SECONDARY DENTAL INSURANCE

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

DOB _____ SS# _____ _ EMPLOYER _____

INSURANCE COMPANY _____ GROUP # _____ CONTRACT#_____

INSURANCE COMPANY ADDRESS _____

INSURANCE PHONE NUMBER _____