HAVASU DENTISTRY

Patient Information

Please Print

Title: ____ Patient First Name: _____ Middle: _____ Last: _____

Preferred Name:_____ Marital Status:_____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Social Security #_____-_____-_____ Patient Date of Birth: _____ Sex: **M** ☑ **F** ☐

Email Address: _____ May we contact you by email? **Yes** ☑ **No** ☐

Emergency Contact: _____ Phone: _____

How did you hear about Havasu Dentistry? _____

*If patient is under the age of 18, Parent or Guardian please fill out below:

Parent/Guardian Name_____

Date of Birth:_____ Social Security #_____-_____-_____

Insurance Information

Do you have Dental Insurance? **Yes** ☑ **No** ☐

Primary Insurance	Secondary Insurance
Subscriber Name:_____	Subscriber Name_____
Subscriber SSN: _____	Subscriber SSN: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber:	Relationship to Subscriber:
☑ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	☐ **Self** ☑ **Spouse** ☐ **Child** ☐ **Other**
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone # _____
Insurance Company: _____	Insurance Company: _____
Insurance Group # _____	Insurance Group #_____
Insurance Phone # _____	Insurance Phone #_____
Insurance Address: _____	Insurance Address: _____

Please present insurance card and Drivers License