SCOTTSDALE
DENTAL SOLUTIONS
DENTAL IMPLANT CENTER

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

PATIENT INFORMATION

Full Legal Name_____ **Gender [ ] M [ ] F**
(Preferred Name)
Birthdate _____ **SS#** _____ **Married [ ] Y [ ] N**

Home Phone: _____ **Work Phone:** _____ **Wireless Phone:** _____

Email Address:_____

Home Address: _____**City**_____ **State** _____ **Zip** _____

Driver's License Number: _____ **State Issued:** _____ **Exp. Date** _____

Employer Name: _____ **Employer Phone** _____

Preferred Contact method for confirmations [ ]HmPhone [ ]WkPhone [ ]WirelessPh [ ]Email

Whom may we thank for referring you to us?
_____
(If someone referred you, please write down their name so we can thank them)

PRIMARY DENTAL INSURANCE

Your relationship to subscriber: [ ]Self [ ] Spouse [ ]Child

Name of Insured_____ **Relationship to Patient:** _____

Date of Birth_____ **Social Security # of Insured:**_____

Insurance Company _____ **Phone #** _____

Employer _____ **ID #**_____ **Group #** _____

Student status if dependent over age 19 (for insurance) [ ]Nonstudent [ ]Fulltime [ ]Parttime
Name of School _____

SECONDARY DENTAL INSURANCE OR MEDICAL/HEALTH INSURANCE

Your relationship to subscriber: [ ]Self [ ] Spouse [ ]Child

Name of Insured_____ **Relationship to Patient:** _____

Date of Birth_____ **Social Security # of Insured:**_____

Insurance Company _____ **Phone #** _____

Employer _____ **ID #**_____ **Group #** _____

Student status if dependent over age 19 (for insurance) [ ]Nonstudent [ ]Fulltime [ ]Parttime
Name of School _____