



cottonwood  
DENTAL

## Patient Information

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Female  Male

Driver's License # \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

## If Patient is A Minor Child

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Who Is Responsible For This Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Dental Insurance

### *Primary Dental Insurance*

Policy Holder Name \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

Name of Employer \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Group Name or ID Number \_\_\_\_\_

### *Secondary Dental Insurance*

Policy Holder Name \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

Name of Employer \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

How Would You Prefer to be contacted by our office:  Phone  Text  Email

How Did You Hear About Our Office: \_\_\_\_\_

If From A Friend or Relative, Whom: \_\_\_\_\_ (We Like to Send Thank-You's)