Thank you for trusting us with you dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us

21116 N. John Wayne Pkwy, Ste B7 • Maricopa, AZ 85139 • (520) 568-3828

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex: ☐ Male ☐ Female Home/ Cell _____ Text? ☐ YES ☐ NO

Referral Source - How did you hear about us? _____

RESPONSIBLE PARTY – PARENT or GUARDIAN INFORMATION

Name _____ Relation to Pt _____

Birthdate _____ SS# _____ Home/ Cell _____

Address _____ City _____ State _____ Zip _____

☐ Married ☐ Single ☐ Separated ☐ Other _____

Email _____ Home/ Cell _____

INSURANCE INFORMATION - PRIMARY

Name of Insured _____ Relation to Patient _____

Date of Birth _____ SS# _____ Home/ Cell _____

Address _____ City _____ State _____ Zip _____

Insurance Name _____ Insurance Phone _____

Insurance ID # _____ Insurance Group # _____

Insurance Address _____ City _____ Zip _____

Employer Name _____ Employer Phone # _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relation to Pt _____

Birthdate _____ SS# _____ Home/ Cell _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone # _____

Insurance Name _____ Insurance Phone _____

Insurance Group # _____ Insurance Alternate ID _____

Insurance Address _____ City _____ Zip _____