ClearBright Cosmetic Dentistry

PERSONAL INFORMATION

NAME:_____ SS#:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: (H):_____ (W):_____ (C):_____

E-MAIL:_____

BIRTH DATE:_____ SEX:_____ MARITAL STATUS:_____

SPOUSE NAME_____ **REFERRED BY**:_____

PERSON RESPONSIBLE FOR ACCOUNT

NAME:_____ RELATIONSHIP:_____ SS#:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: (H)_____ (W)_____ (C)_____

DENTAL INSURANCE INFORMATION

PRIMARY INS. CO & ADDRESS:_____

EMPLOYEE:_____ ID/ SS#_____ RELATIONSHIP:_____

EMPLOYER:_____ BIRTH DATE:_____ GROUP#:_____

SECONDARY INS. CO. & ADDRESS:_____

EMPLOYEE:_____ ID/SS#:_____ RELATIONSHIP:_____

EMPLOYER:_____ BIRTH DATE:_____ GROUP#:_____

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN RELATIVE)

NAME:_____ TELEPHONE:_____

I UNDERSTAND THAT PAYMENT IS MY OBLIGATION REGARDLESS OF INSURANCE OR ANY OTHER THIRD-PARTY INVOLVEMENT.

SIGNATURE:_____ **DATE**:_____