Adel DENTAL GROUP

Adult Patient Information

Name:_____ Nickname:_____

Date of Birth:_____ Social Security Number: _____ □ Male □ Female

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

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

Email: _____ Previous Dentist:_____ Date of Last Visit:_____

Employer:_____ Employer Address: _____

Spouse/Partner's Name: _____ Cell Phone: _____

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

Email: _____ Date of Birth: _____ Social Security Number: _____

Employer:_____ Employer Address: _____

Person responsible for payment:_____

Address (if different than home address): _____

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS!

Whom may we thank for referring you? _____ Is he/she a patient here? □ Yes □ No

□ Building sign
□ Insurance Company
□ Mailer/Advertisement
□ Google
□ Yellow Pages
□ Adel Dental Website
□ Other
_____
_____

Emergency Contact Name: _____ ***Relationship:*** _____

Phone Number: _____ ***Alternate Phone:*** _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Information

Subscriber's Name:_____
Subscriber's Birthdate: _____
Subscriber's SSN or Carrier ID: _____
Employer Name:_____
Policy #: _____
Insurance Company:_____
Insurance Address & Phone:_____
_____

Secondary Dental Insurance Information

Subscriber's Name:_____
Subscriber's Birthdate: _____
Subscriber's SSN or Carrier ID: _____
Employer Name:_____
Policy #: _____
Insurance Company:_____
Insurance Address & Phone:_____
_____

Please note: Payment is expected at time of services. If you provide proper insurance information, we will file your insurance as a courtesy. However, you are responsible for your account within the limits of our credit policy, regardless of insurance coverage.

Signature:_____