AC DENTAL
DENTISTRY & DENTURES

MEDICAL ALERT
ACCOUNT NUMBER_____

PATIENT INFORMATION
(PLEASE PRINT)

(Dr/Mr/Mrs/Ms/Miss) First Middle Last Jr/Sr

Patient SSN Patient Date of Birth M or F Sex

Street City State Zip

( ) ( )
Home Phone Work Phone May we contact you by Email? Y N

How did you hear about us? _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Do you have **Dental** Insurance? ( ) Yes ( ) No
Do you have **Secondary Dental** Insurance? ( ) Yes ( ) No

PRIMARY INSURED

Subscriber Name: _____
Subscriber SSN: _____
Date of Birth: _____
Relationship to Subscriber: ( )Self ( )Spouse ( )Child ( ) Other
Employer Name: _____
Employer Phone #: _____
Insurance Company: _____
Insurance Group #: _____

SECONDARY INSURED

Subscriber Name: _____
Subscriber SSN: _____
Date of Birth: _____
Relationship to Subscriber: ( )Self ( )Spouse ( )Child ( )Other
Employer Name: _____
Employer Phone #: _____
Insurance Company: _____
Insurance Group #: _____

Please present card to receptionist to be photocopied

HIPPA Privacy Practices notice effective April 14, 2003 provided.
Initials/Date _____