PATIENT INFORMATION & INSURANCE FORM

O18 A
Website version

Date of appt: ____________ Time: _______

New Patient of record

Today's Date: _________________

Pt. Name: ______________________________________

Pt. Hm Phone: _______________ Wk Phone ______________ Mobile _____________

Email: ____

Address: ____

City ________________ Zip __________

Date of Birth ______________________________

INSURANCE INFORMATION

Subscriber (Primary) name __________________________ Pt Dependent?

Subscriber's Birth date: _____________ **Name of Employer:** ______________________

Group # ________________ **Member ID #:** _________________________ (NOT SS#)

Name of Dental Insurance: ____

Provider Service Phone #: ___________________________

DSHS (aka Apple Care) #: _____________________________________ WA

If you have co-insurance (dual), please complete the steps for secondary insurance

Subscriber name: ___________________________________ Pt a dependent?

Name of Dental Insurance: ____

Provider Service Phone #: ___________________________

Member ID # (off insurance card): ____

DSHS (aka Apple Care) #: ______________________________ WA