Welcome to Coulee Family Dental

PLEASE COMPLETE THIS GENERAL INFORMATION SO WE MAY SERVE YOU BETTER

Today's Date _____/____/_____ Home phone:_____ Cell #:_____

PATIENT INFORMATION

Name _____ Sex: □ Male □ Female
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Soc. Sec. # _____ Date of birth _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Person responsible for this account? _____

Relationship to patient _____ Is the patient covered by insurance? □ Yes □ No

PRIMARY INSURANCE

Employee Name _____

Address of employee (if different than patient address)_____

Soc. Sec. # _____ Subscriber ID#_____ Date of birth_____

Name & Address of Employer _____

Name & Address of Insurance Company _____

_____ Policy/Group # _____

SECONDARY INSURANCE

Employee Name _____

Soc. Sec. # _____ Date of birth _____

Name & Address of Employer _____

Name & Address of Insurance Company _____

_____ Policy/Group # _____

Responsible Party Signature: