Patient Information

Patient Name ____
Spouse/Guardian Name ____

Address ____

City ____________________________ Zip__________________

Home Phone ______________ Cell Phone ___________________ Work Phone_________
Opt in for Text Reminders and Confirmations ☐ Yes ☐ No

Email ____
Opt in for Email Reminders and Confirmations ☐ Yes ☐ No

DOB ________________________ SSN _________________________
DRIVER LICENSE ___________________

Responsible Party ____
Emergency Contact ____
Who can we thank for referring you? ___________________________________

Primary Dental Insurance

Dental Insurance Company ____
Subscriber Name ____
Subscriber Address ____
Employer ____
SSN ___________________________ DOB ______________________________

Secondary Dental Insurance

Dental Insurance Company ____
Subscriber Name ____
Employer ____
SSN ___________________________ DOB ______________________________

I understand I am responsible for any costs that I may incur at Whispering Pines Dental that my insurance does not cover. I understand that all treatment is paid for at time service is rendered.

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Signature of Patient or Parent/Guardian