SOLTERRA DENTISTRY

Patient Information

Please Print

Title:_____ First Name: _____ Middle: _____ Last:_____

Preferred Name:_____ Marital Status: _____

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

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

Patient Social Security #: _____ Patient Date of Birth: _____ Sex: **M** ☐ **F** ☐

Email Address: _____ May we contact you by email? **Yes** ☐ **No** ☐

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent / Guardian Name: _____

Date of Birth: _____ Social Security #: _____

Insurance Information

Do you have Dental Insurance? **Yes** ☐ **No** ☐

Primary Insurance	Secondary Insurance
Subscriber Name: _____	Subscriber Name: _____
Subscriber SSN: _____	Subscriber SSN: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group # _____	Insurance Group # _____
Insurance Phone # _____	Insurance Phone # _____
Insurance Address: _____	Insurance Address: _____

Please present insurance card and Drivers License