



Welcome to Prairie Plains Dental

Please fill out accurately and completely. The confidential information requested is important for your treatment and dental insurance claims.

Patient Information Preferred Name: _____

Date of Birth: _____

Home Address (city, state, zip, apt#): _____

E-mail Address: _____

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

Social Security Number: _____

Sex (circle): *Male Female* **Marital Status (circle):** *Married Single Divorced Separated Widowed*

Are you the responsible party for this account? Yes No

IF YOU HAVE COPY OF INSURANCE CARD PLEASE GIVE TO FRONT OFFICE

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Dental Insurance Company Name: _____

Insurance Company Address (PO box on back of card): _____

Member ID#: _____ **Group #** _____

Policy Holder's Name (e.g. a parent spouse if not yourself): _____

Policy Holders Date of Birth: _____

Employer Name: _____

Secondary Dental Insurance Company Name: _____

Member ID#: _____ **Group #** _____

Policy Holder's Name (e.g. a parent spouse if not yourself): _____

Policy Holders Date of Birth: _____ **Employer Name:** _____

How were you referred to our office? _____

Emergency Contact Information Name: _____

Relationship: _____ **Phone:** _____