

Patient Information

Date: _____

Patient Name:

_____ Last First M.I.

Patient Date of Birth: _____

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

Address: _____

Street Apt. /Suite

City State Zip

If Minor Parent or Guardian's Name: _____

Insurance Information:

Insured's Name: _____ **Phone Number:** _____

S.S # of Insured: _____ **Date of Birth:** _____

Employer of Insured: _____ **Address:** _____

Insurance Company Name: _____ **Phone #:** _____

Emergency contact:

Name Telephone number(s) Relationship

Physician:

Name Specialty (if applicable) Telephone

Address

Referring dentist:

Name Telephone

While Dr. Bender is not an enrolled provider for any insurance plan, we would be happy to help you file your insurance forms for you. Please present your insurance card(s) to the front desk.