



IntegrityDental

PATIENT INFORMATION

First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____ Current Age: _____ Legal Guardian: N/A _____

Legal Guardian Relationship to Patient: N/A _____

Preferred Phone: _____ Alternative Phone: _____

Mobile Home Work

Mobile Home Work

Email Address: _____ Emergency Contact: _____

Relationship to Patient: _____ Emergency Contact Phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address is the same as Home Address

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Financially Responsible Party Information

Patient is the Financially Responsible Party

Legal Guardian is the Financially Responsible Party

First Name: _____ Last Name: _____ Preferred Name: N/A _____

Date of Birth: _____ Current Age: _____ Email Address: _____

Preferred Phone: _____ Alternative Phone: _____

Mobile Home Work

Mobile Home Work

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address is the same as Home Address

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Primary Insurance Information

No Insurance

Policy Holder: _____

Policy Holder SSN: _____

Policy Holder Date of Birth: _____

Insurance ID Number: _____

Policy Holder's Employer: _____

Policy Holder Relationship to Patient:

Self Spouse Child Other: _____

Insurance Company: _____

Insurance Group Number: _____

Secondary Insurance Information

No Secondary Insurance

Policy Holder: _____

Policy Holder SSN: _____

Policy Holder Date of Birth: _____

Insurance ID Number: _____

Policy Holder's Employer: _____

Policy Holder Relationship to Patient:

Self Spouse Child Other: _____

Insurance Company: _____

Insurance Group Number: _____