Thank you for choosing Grand Rapids Dentistry! We will strive to provide you with the best possible dental care. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

DATE_____

NAME_____ **BIRTHDATE**_____ **SS #**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE_____
(Circle preferred phone)

EMAIL_____ HOW DID YOU LEARN ABOUT US?_____

PREFERRED PHARMACY _____

Person to contact in emergency_____ **RELATIONSHIP**_____ **PHONE**_____

PARTY FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (IF DIFFERENT THAN PATIENT)

NAME_____ **BIRTHDATE**_____ **SS #**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

HOME PHONE _____ CELL PHONE _____ WORK PHONE_____
(Circle preferred phone)

EMAIL_____ **RELATIONSHIP TO PATIENT**_____

PRIMARY DENTAL INSURANCE (IF ANY)

SUBCRIBER NAME_____ **RELATIONSHIP TO PATIENT**_____

ADDRESS (if diff than patient)_____ CITY_____ STATE_____ ZIP_____

DOB_____ **SS #**_____ EMPLOYER_____

INSURANCE CO_____ **GROUP #**_____ **CONTRACT #**_____

INSURANCE CO ADDRESS_____ INSURANCE PHONE_____

SECONDARY DENTAL INSURANCE (IF ANY)

SUBCRIBER NAME_____ **RELATIONSHIP TO PATIENT**_____

ADDRESS (if diff than patient)_____ CITY_____ STATE_____ ZIP_____

DOB_____ **SS #**_____ EMPLOYER_____

INSURANCE CO_____ **GROUP #**_____ **CONTRACT #**_____

INSURANCE CO ADDRESS_____ INSURANCE PHONE_____