BROADWAY HEIGHTS
DENTAL

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be happy to help you! We look forward to working with you in maintaining your dental health.

Patient information (Confidential) **SS#: _____**

Home Phone #: _____ **Cell Phone #: _____**

Work Phone #: _____ **Email: _____**

Address (City and State): _____

Gender: ☐ **Male** ☐ **Female** ☐ **I prefer to not disclose.** ☐ **_____ (Fill in the blank)**

Marital Status: ☐ **Married** ☐ **Single** ☐ **Widow** ☐ **Divorced** ☐ **Minor**

Patient Employer / School : _____

Emergency Contact/ Relationship: _____ Phone #: _____

Who can we thank for your referral? _____

Insurance Information (Primary)

Insurance Company: _____ **ID:# _____**

Group Number: _____

Subscriber: _____ **DOB: _____**

Insurance Information (Secondary)

Insurance Company: _____ **ID:# _____**

Group Number: _____

Subscriber: _____ **DOB: _____**