BEN LOMOND DENTAL

Dr. Wade Larson ● Dr. Brendan Green
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RESPONSIBLE PARTY:

(person receiving billing statement, and responsible for dependent under age 18)

First Name: _____ Last Name: _____ MI: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phn: _____ Work Phn: _____ Cell Phn: _____
Sex: ☐ M ☐ F Birthdate: _____/_____/_____ SSN: _____-_____-_____ Marital Status: _____

Who may we thank for referring you to our office? ☐ phonebook ☐ internet ☐ doctor ☐ other (name) _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____
Address: _____ Apt #: _____ Zip Code: _____
City: _____ State: _____ Cell Phn: _____
Home Phn: _____ Work Phn: _____ Marital Status: _____
Sex: ☐ M ☐ F Birthdate: _____/_____/_____ SSN: _____-_____-_____

PRIMARY DENTAL INSURANCE

Ins. Co.: _____
Ins. Addr: _____
Phone #: _____ Group #: _____
Eff Date: _____ ID#: _____
Employer: _____
Subscriber: _____
Address: _____
City State Zip
Birthdate: _____/_____/_____ SSN: _____-_____-_____

Relationship to Responsible Party:
☐ Self ☐ Spouse ☐ Parent ☐ Step-Parent

SECONDARY DENTAL INSURANCE

Ins. Co.: _____
Ins. Addr: _____
Phone #: _____ Group #: _____
Eff Date: _____ ID#: _____
Employer: _____
Subscriber: _____
Address: _____
City State Zip
Birthdate: _____/_____/_____ SSN: _____-_____-_____

Relationship to Responsible Party:
☐ Self ☐ Spouse ☐ Parent ☐ Step-Parent

APPOINTMENT REMINDERS

We are now sending appointment reminders via email and/or text message. Please provide us with the requested information for yourself/spouse/partner:

_____ Responsible Party Email
_____ Responsible Party Cell Phone
_____ Spouse/Partner Email
_____ Spouse/Partner Cell Phone

☐ I would prefer not to receive appointment reminders by email or text message. (If checked, you will receive a courtesy phone call reminder)