Petaluma Dental Group

# Welcome to our Practice

Please take time to fill out this form completely. The more we learn about you the better care we can provide.
We look forward to working with you to maintain a healthy, happy relationship.

## Dental Insurance

Today's Date: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

## Account Responsible Party

Account Holder First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State/ Zip: _____

Date of Birth: _____ SSN: _____ Driver's License: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Employer: _____ Occupation: _____

Employer Address: _____ City/ State: _____

**Primary Carrier:**

Insurance Co Name: _____ Insurance Co Phone: _____

Insurance Co Address: _____ City/ State: _____

Group No. (Plan or Policy) _____ Insured's I.D. Number: _____

Insured's Name: _____ Insured's SSN: _____

Insured's Employer Name: _____

**Secondary Carrier**

Insurance Co Name: _____ Insurance Co Phone: _____

Insurance Co Address: _____ City/ State: _____

Group No. (Plan or Policy) _____ Insured's I.D. Number: _____

Insured's Name: _____ Insured's SSN: _____

Insured's Employer Name: _____

**Medical Carrier**

Insurance Co Name: _____ Insurance Co Phone: _____

Insurance Co Address: _____ City/ State: _____

Group No. (Plan or Policy) _____ Insured's I.D. Number: _____

Insured's Name: _____ Insured's SSN: _____

Insured's Employer Name: _____