ELITE DENTAL SPECIALISTS

Date:	Referring Dr:

PATIENT INFORMATION

First Name:	Last Name:	Middle:

Date of birth: Month/Date/Year	Gender: ☐F ☐M	Phone: Home / Cellphone

Address:	City:	State	Zip:

SSN:	Email:
Employer's Name:	Employers Phone #:

INSURANCE INFORMATION (PRIMARY INS)

Will you be using any dental insurance? Yes ☐ No ☐ - Do you have Secondary insurance? Yes ☐ No ☐

Name of primay insurance?

Subscriber's Name:	Subscribers S.S #:	Date of Birth: / /

Secondary insurance information

Dental Insurance Name (Secondary):

Subscribers Name:	Subscribers SS or ID #:	Date of Birth:

➢ Please Read and Sign

The above information is true to my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elite Dental Specialists insurance to release any information required to process my claims.

Patient/Guardian Sign: ***Date:***

Please fill out the Health History on the back side!