AVALON DENTISTRY
FAMILY & COSMETIC

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

SSN: _____ Driver's License Number & Expiration: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Phone: _____

Previous Dentist: _____ Dental Office: _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Other _____

PRIMARY INSURANCE INFORMATION

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

SECONDARY INSURANCE INFORMATION

◯ No Secondary Dental Insurance

◯ Secondary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

RESPONSIBLE PARTY

◯ Patient is the responsible party

◯ Someone else is the responsible party

Name of person Responsible: _____ Relationship to Patient: _____

Address: _____ Birth Date: _____

Phone Numer: _____ Email: _____

Name of Employer: _____

SSN: _____ Driver's License Number & Expiration: _____

Is this person a patient of the practice?: _____