anderson DENTAL

Thank you for trusting us with your dental care. We Promise to do our best to provide you with the finest Care available. If you have any questions please do not hesitate to call us. 509-585-2500

PATIENT INFORMATION _____

Name _____ Preferred Name _____ Middle Initial_____

Address _____ City _____ State _____ZIP _____

E-Mail_____ Cell phone_____ home phone_____

Social Security number _____ Birthdate _____ Sex: **M F**

Employer _____ Work phone _____

How did you hear about us or whom may we thank for referring you? _____

Name of person responsible for account _____ Relationship _____

Birthdate _____ Social Security number _____ phone number _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work phone _____

Currently a patient in our office? **YES NO**

Name of Insured _____ Relationship _____

Birthdate _____ Social Security number _____ years employed _____

Employer _____ Work phone _____

Insurance Company _____ID # _____ Group # _____

Name of Secondary Insured _____ Relationship _____

Birthdate _____ Social Security number _____ years employed _____

Employer _____ Work phone _____

Insurance Company _____ID # _____ Group # _____