WELCOME TO PREMIER DENTAL SPA

We are pleased that you have selected us as your dental care provider.

Today's Date: _____ Email: _____

PATIENT INFORMATION

Last Name _____ First Name _____
Address _____
City, State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____
Birth date _____ Sex M __F __ Social Security Number _____
Employer _____
Student: Yes ____ No ____ Name of School _____
Name of Emergency Contact _____ Phone Number _____

DENTAL INSURANCE INFORMATION

Last Name of Employee _____ First Name _____
Address _____
City, State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____
Employer _____ Relationship to Patient ___Self __Spouse ___Child ___
Birth date _____ Sex M __F __ Social Security Number _____
Name of Insurance Co. _____ Phone Number _____
I.D. Number _____ Group Number _____

SECONDARY DENTAL INSURANCE INFORMATION

Last Name of Employee _____ First Name _____
Address _____
City, State _____ Zip _____
Home Phone _____ Work Phone _____ Ext. _____
Employer _____ Relationship to Patient ___Self __Spouse ___Child ___
Birth date _____ Sex M __F __ Social Security Number _____
Name of Insurance Co. _____ Phone Number _____
I.D. Number _____ Group Number _____