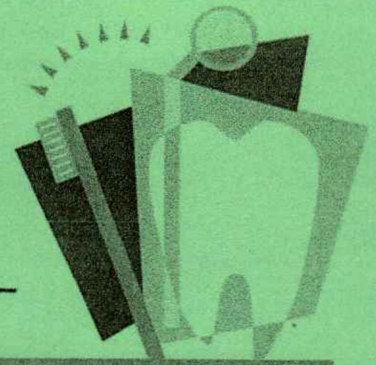
Welcome

to Lifetime Dental Health



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date ______________________ Soc. Sec # ______________________ Birthdate ______________________

Name ____
Last Name First Name Middle

Email ____

Address ____ Phone ______________________

City ______________________________________ State ______________ Zip ______________

Sex: ❑ M ❑ F Status: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employer ____ Business Phone ______________________

Business Address: ______________________________________ Occupation ______________________

Who should we thank for referring you? ____

In case of emergency, who should we contact? ______________________ Phone ______________________

PRIMARY DENTAL INSURANCE

Person Responsible for Account ____

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ____ Phone ______________________

City ____ State ____________ Zip ____________

Responsible Party Employed By ______________________________ Business Phone ______________

Business Address ______________________________________ Occupation ______________________

Insurance Company ____

Insurance Address ____

Subscriber I.D. # ______________________________________ Group # ______________________

SECONDARY DENTAL INSURANCE

Insured Name ____
Last Name First Name Middle

Relationship to Patient ______________________ Birthdate ______________ Soc Sec. # ______________

Address ____ Phone ______________________

City ______________________________ State ______________________ Zip ______________________

Insured Employed By ______________________________________ Business Phone ______________________

Insurance Company ______________________________ Address ______________________________

Subscriber I.D. # ______________________________ Group # ______________________________