



David Lee, DDS, FAGD

Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____
 Address (Street, City, State, ZIP) _____
 Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured's social security no. _____
 Insured's employer name _____

Person Financially Responsible for Account

Name _____ Relationship to patient _____
 Social security no. _____ Phone _____
 Driver's license no. _____ Date of birth _____
 Address (Street, City, State, ZIP) _____
 Employer _____

Preference of payment: Cash Credit Card

Visa/MC/AMEX no. _____ Exp. date _____

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? Yes No

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____

Doctor's comments:

