Biltmore Dental Group

Patient Information

Last Name _____ First _____ M.I. _____

Preferred Name _____ Date of Birth _____ Age _____

Address _____City_____ State_____ Zip_____

Social Security#_____ Marital Status *circle one*- S / M / D / W Sex *circle one*- M / F

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Preferred method of confirmation *circle one*- hm# / cell# / email

Family Physician _____ Office phone _____

Emergency Contact _____ Phone _____ Relationship _____

Who may we thank for referring you to our office _____?

Policy Holder Information / Financial Responsibility

Primary Dental Insurance _____ ID# _____ Grp#_____

Insurance Phone _____ Claim Mailing Address _____

Policy Holder Name _____ Date of Birth _____ Soc. Sec. #_____

Relationship _____ Policy Holder Employer _____ Wk # _____

Secondary Dental Insurance _____ ID# _____ Grp#_____

Insurance Phone _____ Claim Mailing Address _____

Policy Holder Name _____ Date of Birth _____ Soc. Sec. #_____

Relationship _____ Policy Holder Employer _____ Wk # _____