



Billing Information

Patient Name: _____ Preferred Name: _____

How did you hear about Gorge Dental? _____

Previous Dentist Name & Phone #: _____

RESPONSIBLE PARTY

Name: _____ Relationship: _____

Mailing Address: _____ City/State/Zip: _____

Street Address: _____ City/State/Zip: _____

Social Security #: ____ - ____ - ____ Phone (H): (____) ____ - ____ (C): (____) ____ - ____

Date of Birth: _____ Email: _____

Employer Name and Phone #: _____

PRIMARY DENTAL INSURANCE INFORMATION

Full Name of Insured: _____

Mailing Address: _____ City/State/Zip: _____

Phone (H): (____) ____ - ____ (C): (____) ____ - ____

Relationship to Patient: ____ Self ____ Spouse ____ Child ____ Other

Employer Name & Phone #: _____

Insurance Company Name: _____

Insurance Company Phone #: (____) ____ - ____

Insurance Address: _____ City/State/Zip: _____

Member ID #: _____ Group #: _____

Insured Social Security #: ____ - ____ - ____ Insured Date of Birth: _____

Do you have secondary dental insurance? If so, please advise _____