

Welcome to Legacy Dental Arts

Patient Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Mailing Address: _____

(City): _____ (State): _____ (Zip Code): _____

Email (For appointment reminders): _____

Insurance Information

Primary Insurance

Policy Holder: _____ Is policy Holder a Patient? ☐ Yes ☐ No

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent or Guardian

Policy Holders address if different: _____

Employer: _____ Social Security # _____

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insurance Company Name and Address: _____

Insurance Company Phone Number: _____

Secondary Insurance

Policy Holder: _____ Is policy Holder a Patient? ☐ Yes ☐ No

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent or Guardian

Policy Holders Address if different: _____

Employer: _____ Social Security # _____

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insurance Company Name and Address: _____

Insurance Company Phone Number: _____

