TELEPHONE INFORMATION SLIP

Date_____ Appointment Date_____ Time_____

_____New Patient _____Former Patient _____Emergency Patient

Name_____

Parent or Guardian_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work_____ Cell_____

Referred by_____

_____Toothache _____Lost Filling _____Bleedings Gums _____Fever

_____Mobility _____Pain on Pressure _____Sweets _____Cold

Other_____

Premedicate_____ Allergic to_____

INSURANCE _____Yes _____No

PRIMARY INSURANCE

Subscriber Name_____ Subscriber SS_____

Date of Birth_____ Employer_____

Insurance Company Name_____

Insurance Phone Number_____ Policy/Group_____

SECONDARY INSURANCE

Subscriber Name_____ Subscriber SS_____

Date of Birth_____ Employer_____

Insurance Company Name_____

Insurance Phone Number_____ Policy Group_____