Welcome to Rappold Family Dentistry

Patient Information:

First Name: ________________________________ Last Name: ___________________________________ DOB:____________

Address: ____

Mobile #: _______________________________________ Home #:____

Email: ____ SSN:____________________________

Responsible Party (If someone other than patient):

First Name: ________________________________ Last Name: ___________________________________ DOB:_____________

Address: ____

Mobile #: ___________________________________ Home #:___________________________________SSN:________________

Email: ____ Relationship to Patient: _______________________

Insurance Information:

Name of Policy Holder: ____ DOB: __________________________

Address: ____

Mobile #: ____ Home #:____

Email: ____ Relationship to Patient: __________________________

Employer Name: ____ Insurance Carrier: ___________________________________

Group/Policy #: ________________________________ Member ID/SSN of Policy Holder: ______________________________

Secondary Insurance:

Name of Policy Holder: ____ DOB: __________________________

Address: ____

Mobile #: _______________________________________ Home #:____

Email: ____ Relationship to Patient: _______________________

Employer Name: ___________________________________ Insurance Carrier: ____

Group/Policy #: __________________________ Member ID/SSN of Policy Holder: ____________________________________

Preferred Pharmacy: _________________________________ Location: ____

How did you hear about our practice? ____