# Valley Dental

FAMILY DENTISTRY, ORHTODONTICS, & ENDODONT1CS

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Patient Information

***Welcome***

Patient Name:________________________________Date:________________
Street Address____________________________City/State__________________
Zip Code__________Home Phone__________________Cell Phone_______________
Work Phone________________Email Address______________________________
Preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Cell Phone
Date of Birth___________SS#____________________________________________
Employer______________________Address________________________________
If patient is a full-time student, name of school_________________________________
Drivers License State & Number__________________________________________
**Whom may we thank for referring you?**___________________________________

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## Primary Dental Insurance

Policy Holder_______________________Relation_______________DOB_________
Address (if different)_____________________________________________________
Policy Holders Employer______________________Insurance Co________________
Subscriber #______________________________Group #______________________
Insurance Co Address_____________________________City/State______________
Zip Code_______________Phone #__________________________________________

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## Secondary Dental Insurance

Policy Holder________________________Relation______________DOB__________
Address (if different)_____________________________________________________
Policy Holders Employer______________________Insurance Co________________
Subscriber #_______________________________Group #______________________
Insurance Co Address______________________________City/ State_____________
Zip Code________________Phone #_________________________________________

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**Signature:**___________________________________ **Date:** ____________________

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