

# Valley Dental

**Full Legal Name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_  
*First MI Last*

**Male**  **Female**  **Date of Birth:** \_\_\_\_\_ **Social Security#:** \_\_\_\_\_  
*(required for all patients 18yrs+)*

**Home#:** \_\_\_\_\_ **Work#:** \_\_\_\_\_ **Cell#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

## For Patients Under 18:

**Parent/Guardian Name:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Address(If different from above):** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

## **Do you have Dental Insurance? YES NO**

Dental Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ ID#/SS# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

## **Additional (Secondary) Insurance**

Dental Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_ ID#/SS# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

**I understand that I am responsible for all costs of dental treatment, regardless of any insurance, and/or financial situations.**

**Signature of Responsible Party:** \_\_\_\_\_ **Date** \_\_\_\_\_

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