Deer Creek Dental Care
Patient Information

First Name: _____ Last Name: _____ MI: _____

Address: _____

City, State, Zip: _____

Home Phone: _____Cell Phone: _____

Email:_____

Gender: Male Female Marital Status: _____

Birth Date: _____ Social Security #:_____

Employer: _____

Dental Insurance

Name of Policy Holder: _____ Relationship:_____

Employer or Self Paid Policy: _____

Policy Holder SSN: _____ Policy Holder DOB: _____

Insurance Company: _____ Group #:_____

If you do not have dental insurance, payment for all services is due on the date of service.

Patient /Responsible Party _____ Date _____