Posh Dental Arts

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Phone: 301-645-8530

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Patient information

Name: _____Soc. Sec. # _____
Address_____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

Primary Insurance

Person Responsible for Account _____Driver's License #_____
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Email _____ Cell Phone _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____ Date Employed _____
Insurance Company _____ Union/ Local # _____ Phone _____
Contact # _____ Group # _____ Subscriber ID# _____
Name of other dependent under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ YES ☐ NO Relation to Patient _____
Subscriber Name _____ Driver's License #_____ Birth Date_____
Address (if different from patient) _____ Soc.Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Email _____ Cell Phone _____
Person Responsible Employed by _____ Business Phone _____
Business Email _____ Date Employed _____
Insurance Company _____ Phone _____
Contact # _____ Group # _____ Subscriber ID# _____
Name of other dependent under this plan _____

Patient/ Responsible Party's Signature _____ Date _____