WELCOME TO SPOKANE VALLEY DENTAL

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help!

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Zip _____

Email (optional) _____ Cell Phone _____ Soc. Sec.# _____

Whom May We Thank for Referring You? _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State/Zip _____

Spouse or Parent/Guardian's Name _____ Work Phone _____

Spouse or Parent/Guardian's Employer _____ City _____

Person to Contact in Case of Emergency (living in same home) _____ Phone _____

Person to Contact in Case of Emergency (not living in same home) _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email (optional) _____ Cell Phone _____

Driver's License # _____ Birthdate _____ SSN _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Are there other family members ☐ Yes ☐ No

For your convenience, we offer the following methods of payment, Please check the option you prefer:

☐ Cash ☐ Personal Check Credit Card: ☐ Visa ☐ MasterCard ☐ Care Credit

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Company Address _____ City _____ State/Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Company Address _____ City _____ State/Zip _____

SPOKANE VALLEY DENTAL
200 N. Mullan Road, Suite 103 · Spokane, WA 99206
Phone: 509.928.8431 · Fax: 509.928.3522 · E-Mail: info@spokanevalleydental.com

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