ICONIC DENTAL

CENTER FOR DENTAL REHABILITATION

Welcome to Iconic Dental

Patient Information

Name: _____ Date of Birth: _____
Address: _____ City: _____State/Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Preferred Contact Method: ☐ Phone ☐ Text ☐ Email
Employer: _____
Occupation: _____ Social Security #: _____ (For insurance billing only)
Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse or Parent/Guardian's Name: _____

Emergency Contact

Name: _____ Date of Birth: _____
Address: _____ City: _____State/Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____

Referral Information

Who may we thank for referring you? _____
☐ Google ☐ Instagram ☐ Facebook ☐ Friend/Family ☐ Other _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____
Address / Cross Streets: _____

Dental Insurance Information

Primary Insurance

Subscriber Name: _____ Date of Birth: _____
Subscriber ID #: _____ Group #: _____
Employer: _____ Insurance Company: _____
Insurance Phone #: _____ Relationship to Patient: _____

Secondary Insurance (if applicable)

Subscriber Name: _____ Date of Birth: _____
Subscriber ID #: _____ Group #: _____
Employer: _____ Insurance Company: _____
Insurance Phone #: _____ Relationship to Patient: _____

Additional Information

Do you have a Power of Attorney for Healthcare? ☐ Yes ☐ No
Person Financially Responsible (if not patient): _____
Relationship to Patient: _____ Phone #: _____

Signature of Patient (or Guardian): _____ Date: _____