## Welcome to Sunrise Dental

### PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Birth Date: _____ Soc. Sec: _____

E-mail: _____

**Insurance Subscriber**/ Responsible Party (skip this part if patient is subscriber and only list your employer)

First Name: _____ Last Name: _____ Middle Initial: _____

Address (complete if different from Patient): _____

City, State, Zip: _____

Employer: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec: _____

**Referral Source:** _____ **Preferred Pharmacy**: _____

### PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

### SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____