WEST DENTAL IMPLANTS
&
PROSTHETICS

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____
Nickname _____ Male ☐ Female ☐ Birthdate _____ Preferred Salutation _____
Home Address _____ City _____ State _____ Zip _____
Cell Phone _____ Landline Home _____ Work Phone _____
Mailing Address _____ SS# _____
Email address _____
Employer _____ Employer Address _____
Marital Status: ☐ Married ☐ Single ☐ Other _____

PERSON RESPONSIBLE FOR PAYMENT IF NOT YOURSELF

Name _____ Relationship to Patient _____
SS# _____ Telephone Number _____
Employer _____ Work Number _____
Address _____ Home Phone _____
Contact Name, address and phone number _____
Who may we thank for referring you to our office: _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT IF NOT YOURSELF

PRIMARY INSURANCE:

Name of Insured _____ Date of Birth _____
Relationship to Insured _____ SS# _____
Insurance Company _____ Telephone Number _____
Group Number _____ Policy Number _____

SECONDARY INSURANCE:

Name of Insured _____ Date of Birth _____
Relationship to Insured _____ SS# _____
Insurance Company _____ Telephone Number _____
Group Number _____ Policy Number _____

GENERAL INFORMATION

We are willing to help you receive the maximum benefits your dental program provides. Please provide us with a complete Insurance Form & Card from your Insurance Company. Your dental benefit program is a contract between you and your employer, and the Insurance Company. This office is not a party to this contract. Our fees are generally, but not always covered by all dental programs, unless otherwise specified.

I UNDERSTAND I AM RESPONSIBLE FOR MY ACCOUNT.

Signature _____ **Date:** _____

NATHAN ROBISON, DDS, MDS | *p:* 970.259.5600 | *f:* 970.247.2820
2323 W. 2nd Ave. Suite D, Durango, 81301 | westdentalimplants.com