816-600-6330 PremierDentalLeesSummit.com
Premier Dental
1648 SE Blue Parkway, Lee's Summit, MO 64063

**Patient Information:**

First Name: Last Name: Middle Initial:

Preferred Name:

Address: City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #:

Sex: □ Female □ Male

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Other_____.

E-mail: □ I would like to receive email correspondences

Text Messages: □ I would like to receive text message □ I would NOT like to receive text messages

Referred By: □ Family □ Friend □ Mailer □ Internet □ Other_____

Preferred Pharmacy:

Does the Patient have Dental Insurance? □ Yes □ No

Is the Patient the Policy Holder for the Insurance Policy? □ Yes □ No

Is the Patient the Responsible Party for this account? □ Yes □ No

**Responsible Party Information:** **(if someone other than the patient)**

First Name: Last Name: Middle Initial:

Address: City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #:

**Dental Insurance Information:** **(please provide your Dental Insurance Card to front desk)**

Name of Insured:

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

□ Primary Policy □ Secondary Policy