DR. RICHARD G. WYNE
family dentistry

Patient Information

Name:_____ DOB:____/_____/_____ SSN:_____/_____/_____
Last Name First Name Mo Day Year

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____ Cell Phone:_____

Email:_____ Can we send text / email confirmations? Y / N Sex: M / F

How did you hear about us? Check one: Referral _____ Internet_____ Insurance_____ Mailer_____ Walk-In_____ Other_____

Emergency contact:_____ Phone number:_____

Primary Insurance

Subscriber's Name:_____ Relation to patient:_____
Last Name First Name

Subscriber's DOB:____/_____/_____ Subscriber's SSN: _____/_____/_____ Subscriber's Phone:_____
Mo Day Year

Subscriber Employed by:_____ Occupation:_____

Insurance Company:_____ Phone:_____

Member ID #:_____ Group #_____ Enrollment #:_____

Name of dependents under this plan:_____

Secondary Insurance (if applicable)

Subscriber's Name:_____ Relation to patient:_____
Last Name First Name

Subscriber's DOB:_____/_____/_____ Subscriber's SSN: _____/_____/_____ Subscriber's Phone:_____
Mo Day Year

Subscriber Employed by:_____ Occupation:_____

Insurance Company:_____ Phone:_____

Member ID #:_____ Group #_____ Enrollment #:_____

Name of dependents under this plan:_____