Infinity Dental 8940 W. Tropicana Ave Las Vegas, NV. 89147 702-248-4448

## Confidential Patient Information Please print clearly.

Date:			

I. Patient Information	on					
Name:		Birthdate:		Gender:		
Address:		City & Sta	ite:	Zip:		
Home Phone: ()_	Cell Phor	ne: ()	Email:			
Social Security #:		Driver's Licen	nse #:			
Employer's Name:		Phone #: (	()	Marital status:		
II. Responsible Party	(Primary Insurance Infor	mation)				
			Patient:			
	DL#	<u></u> :	Birthdate:			
				Zip:		
Name of insurance:		Phor	Phone #:			
Union/Local:	Group number:		Occupation:			
Date of Hire:						
III. Cocond Incomen	information (Only comp	lata if matiant has a	athor coverage)			
	information (Only compl	•				
Name:	DI#	Kelationship to P	atient:			
Name of Employer:	DL#	Phone Number	birthdate:_			
Address:		Priorie Numbe	er	Zip:		
Name of insurance		City	ne #·	zip		
Union/Local	Group number:	1 1101	Occupation:			
IV. Getting to know	you and your family					
			Last dental x-rays	taken?		
When was your last dental visit?:			What treatment w	What treatment was performed?:		
Please list all immed	liate family members:					
Name:	Relationship:	Birthdate:	Date of last dent	al visit:		
V. Emergency Contac	ct (Friend or relative not l	iving with vou)				
	or (Friend or Felderve Hot)					
Name:		Phone: ()				
SO WE MAY BILL YOUR IT	NSURANCE DIRECTLY, PLEASE S	GN				
				e. I understand that I am financially		
				y information necessary to bill my		
insurance carrier. In the	event of default, I understand	.naτ i wiii be charged ar	na i agree to pay all reaso	onable collection charges.		
			Date:			

Signature of Patient/Guardian