John Marietta, DDS – 208 W. Cloud, Salina, Ks 67401 – phone 785-825-7557, fax – 785-825-7666
www.salinadentist.com

ACCOUNT INFORMATION

GUARANTOR 1: Person primarily financially responsible, where the statements will be mailed. i.e. parent, spouse, guardian

Last name:	First name:
Middle Name:	Title:
Address:	

City:	State:	Zip:

[ ] Full time employment [ ] Full time student
[ ] Part time employment [ ] Part time student
[ ] Retired

Employer:

Name of **employer** that carries dental insurance for guarantor 1:

Dental insurance carrier/company:	Group #:

Name of **employer** that carries medical insurance guarantor 1 :

Medical insurance carrier/company:	Group #:

BCBS #:

GUARANTOR 1

Home phone:

Work phone:

Cell phone:

SS #: (provide only if required for ins of if you will be using Care Credit financing.)

Date of birth:

Sex:

Marital status:

Please allow us to copy your insurance card. Thanks!

GUARANTOR 2 (Person carrying secondary or other insurance – spouse, ex-spouse, step parent, etc.)

Last name:	First name:
Middle Name:	Title:
Address:	

City:	State:	Zip:

[ ] Full time employment [ ] Full time student
[ ] Part time employment [ ] Part time student
[ ] Retired

Employer:

Name of **employer** that carries **dental** insurance for guarantor 1:

Dental insurance carrier/company:	Group #:

Name of **employer** that carries **medical** insurance guarantor 1 :

Medical insurance carrier/company:	Group #:

BCBS #:

GUARANTOR 2

Home phone:

Work phone:

Cell phone:

SS #: (provide only if required for ins of if you will be using Care Credit financing.)

Date of birth:

Sex:

Marital status:

Please allow us to copy your insurance card. Thanks!

PATIENT INFORMATION

Last Name: First name: Nickname:

Middle name: Title: Home phone:

Address: Work phone:

City: State: Zip: Cell phone:

Information

Sex:	Marital status:	Social Security #:
Date of birth:	Provide Social Security # only if required for insurance or if applying for the Care Credit financing option.	
Whom may we thank for your referral?		

Insurance

Who carries the primary **dental** insurance for this patient? (for dual coverage this the patient or if a child the parent with first birthday of year)	Patient's relationship to account guarantor 1: [ ] self, [ ] spouse, [ ] child, [ ] dependent, [ ] handicapped dependent, [ ] significant other
Who carries the secondary **dental** insurance for this patient? (for dual coverage this the spouse or if a child the parent with first birthday of year)	Patient's relationship to account guarantor 2: [ ] self, [ ] spouse, [ ] child, [ ] dependent, [ ] handicapped dependent, [ ] significant other
Who carries the primary **medical** insurance for this patient? (for dual coverage this the patient or if a child the parent with first birthday of year)	
Who carries the primary **medica**l insurance for this patient? (for dual coverage this the spouse or if a child the parent with first birthday of year)	

Additional contacts

Other cell phone: Other Home phone:

Fax: Other Work phone:

Beeper: Other cell phone:

Email 1:

Email 2:

Emergency contact person:

Emergency contact person phone: