Victor Immel, DMD, PS

Welcome!

Patient Information

Name:_____ **Home Ph:**_____ **Cell Ph**_____

Date: _____ **Soc. Sec. #**_____ **Birthday:**_____ **Email** _____

Address:_____**ST:**_____**Zip:**_____**Male/Female** Female

Employer:_____**Occupation:**_____**How Long?**_____

Work Ph:_____**May we call you at work?**_____**Marital Status:**_____

Person to contact in case of emergency:_____**Ph:**_____

Whom may we thank for referring you?_____**Email:**_____

Spouse Information

Name:_____**Soc. Sec. #:**_____**Birthday:**_____

Employer:_____**Occupation:**_____**How Long?**_____

Business Ph:_____**Cell Ph:**_____

Person Responsible for Account

Name:_____**Relationship to Patient:**_____

Address (if different than patient's):_____

Employer:_____**Work Ph:**_____**Birthday:**_____

Soc. Sec. #:_____**Cell Ph:**_____

Dental Insurance

Name of Insured:_____**Relationship to Patient:**_____

Name of Insurance:_____**Insurance Address:**_____

Subscribers ID#:_____**Group #:**_____**SS#:**_____

Insured's Employer:_____**Insured's Birthday:**_____

Secondary Insurance

Name of Insured:_____**Relationship to Patient:**_____

Name of Insurance: _____**Insurance Address:** _____

Subscriber's ID # _____ **Group #** _____**SS #** _____

Insured's Employer: _____**Insured's Birthday:** _____