KOPP DENTAL
AND ASSOCIATES

Where the Patient is Our Primary Concern

PATIENT INFORMATION

DATE: _____

PATIENT NAME: MR. __MRS. __ MS. __MISS __DR. _____

HOME ADDRESS: _____
Street City Zip

HOME PHONE: (_____) _____-_____ **CELL PHONE:** (_____) _____-_____ **D.O.B.**_____ **SEX** _____

☐ **I authorize any agent of Kopp Dental to contact me via text/email regarding my treatment and or finances.**

MARITAL STATUS (S___) (M___) (D___) (W___) SS# _____-_____-_____ **DRIVER'S License #**_____-_____-_____

EMPLOYER NAME _____ **Employer Address** _____

WORK PHONE: (_____) _____-_____X_____ **May we call you at work?** YES _____ NO _____

E-MAIL _____

INSURANCE INFORMATION

DENTAL INSURANCE? YES ___ NO ___ **Policy Holders Name** _____

Employer _____ **Employer Address** _____

Insurance Company _____ **GROUP #** _____

Policy holders ID or SS# _____ **Policy Holder DOB:** _____

****YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR EMPLOYER. IT IS IMPOSSIBLE FOR US TO KNOW EVERY PATIENTS POLICY AS ALL OF THEM DIFFER ANY CLAIM NOT COVERED FOR ANY REASON IS YOUR RESPONSIBILITY. (IE: MISSING TOOTH CLAUSE, WAITING PERIOD, NON-COVERED PROCEDURE, IMPLANTS) PLEASE NOTE KOPP DENTAL IS NOT IN ANY INSURANCE NETWORKS**

Who may we thank for referring you? _____

Reason for Consultation ? _____