

Kenneth A. Ingber, D.M.D. Charles Porvznik, D.M.D.

Which Dentist are you here to see? (circle one) Dr. Ingber Dr. Porvaznik Either

Patient Name_____ Date_____

Address_____ City/State/Zip_____

Home #_____ Work #_____ Cell #_____ SSN_____

Email Address_____ Employer_____

Date of Birth_____ Emergency Contact_____

Relationship_____ Telephone #_____

Whom may we thank for referring you?_____

How would you like to confirm future appointments?(circle one) Email Phone Text

Primary Insurance

Policy Holder_____

Relationship_____ Date of Birth(if different from above)_____

Address(if different from above)_____

City/State/Zip_____ Policy Holder's Employer_____

Insurance Company_____ ID/Subscriber #_____

Group #_____ Insurance Company Address_____

City/State/Zip_____ Phone #_____

Do you have a secondary insurance policy?_____ Insurance Company_____

Policy Holder_____ Id/Subscriber #_____

Group #_____ Insurance company address_____