CANYON RIDGE DENTAL SPECIALISTS

Welcome to Canyon Ridge Dental Specialist

PATIENT INFORMATION

Patients LEGAL Name: Last: _____ **First:** _____

Address: _____

City: _____**State:** _____ **Zip Code:** _____**Social Security:** _____

Home #: _____**Cell #:** _____ **Sex:** _____ **Age:** _____ **D.O.B.:** _____

Email Address: _____

Preferred Pharmacy _____**Phone #**_____**Address**_____

INSURANCE INFORMATION

PRIMARY DENTAL

Plan Name: _____**Phone #:**_____

Policy Holder Name: _____ **Date of Birth:** _____

Member ID #: _____ **Group #:** _____

Policy Holder Employer: _____

SECONDARY DENTAL

Plan Name: _____ **Phone #:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Member ID #: _____**Group #:** _____

OFFICIAL USE_____

Please Complete Health History on Reverse Side ➔