Patient Information

Columbia City Dental

Name _____ Preferred Name _____

Email _____ Is it OK to email you? ☐ No ☐ Yes

Would you like to receive text reminders for appointments? ☐ No ☐ Yes

Preferred way to contact _____

Referred by _____

Marital status (for insurance purposes) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Other family members seen at this office _____

Do you have dental insurance? ☐ No ☐ Yes If yes, please bring insurance card(s) for dental coverage to your visit.

Your relationship to subscriber ☐ Self ☐ Spouse ☐ Child

Subscriber Name _____ Subscriber ID # _____

Subscriber DOB_____ SSN (if subscriber ID unknown) _____

Insurance Company _____ Phone _____

Employer _____

Group Name _____Group # _____