

Bay View Dental Care

3380 S. Kinnickinnic Ave.
Milwaukee, WI 53207
Phone: 414-482-2090 Fax: 414-482-0265

PATIENT INFORMATION

GENERAL INFORMATION

Mr. Ms. Mrs. Miss Dr.:

First _____ Middle Initial _____ Last _____

If above is a minor, name of parent / guardian:

Address:

City: _____ State: _____ Zip: _____

Phone: H _____ W1 _____ W2 _____

E-mail: _____

DOB: _____ SSN: _____

Sex: M F

Full time Student
Where? _____

Employer: _____ Occupation: _____

Address:

City: _____ State: _____ Zip: _____

Marital Status: S M D W Name of spouse/partner: _____

DENTAL PLAN INFORMATION

Primary person insured: None Self Spouse Parent Other

Policy Holder's Employer: _____ Phone: _____

Address:

City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone: _____

Address:

City: _____ State: _____ Zip: _____

Plan Name: _____ Group #: _____

ID/SSN: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: H _____ W1 _____ W2 _____

I authorize the release of information required for processing.

Signature _____ Date _____