Valerie D. Saulsbury-Effertz DDS 9906 College Boulevard Overland Park, KS 66210

PATIENT INFORMATION

Name: _____ I prefer to be called _____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child Birth date: ____/____/____ Age: _____ SS #: _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone: ( ) _____ Work: ( ) _____ ext _____

Cell: ( ) _____ E-mail Address: _____

Employer: _____

City _____ State _____ Zip_____

Patient's Spouse, Parent or Guardian

Name: _____ Birth date: ____/____/____ Relation: _____

Billing Address: _____

City _____State _____ Zip_____

Email: _____

Home Phone: ( ) _____ Work: ( ) _____ SS#: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Cell Phone: ( ) _____ Work Phone: ( ) _____ ext _____

Whom may we thank for referring you? _____

Are you covered by Dental Insurance? YES _____ NO _____ If YES, complete insurance information below:

INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: ( ) _____

Group/Policy#: _____

Insured's Name: _____ _____ Insured's Birth date: ____/____/____ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: ( ) _____

Group/Policy#: _____

Insured's Name: _____ Insured's Birth date: ____/____/____ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

We send appointment reminders by e-mail and text. If you would like to opt out, please indicate here.

[ ] do not e-mail [ ] do not text message