

# WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please print this form, fill it out, and bring it with you to your appointment. If you have any questions, please call us – we will be happy to help. 480-998-7775

## About You...

## Dental Insurance

Name (First) (MI) (Last) \_\_\_\_\_  
 Mr.  Mrs.  Ms.  Dr. I prefer to be called \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Home  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
Home Phone \_\_\_\_\_ Mobile/Pager # \_\_\_\_\_  
Work # \_\_\_\_\_ Ext. \_\_\_\_\_  
E-mail Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
How long there \_\_\_\_\_ Occupation \_\_\_\_\_  
Where and when are the best times to reach you? \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Other family members seen by us \_\_\_\_\_

## Spouse Information...

His/Her Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Work # \_\_\_\_\_ Ext. \_\_\_\_\_  
Birthdate \_\_\_\_\_

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*Primary Dental Insurance*  
Name of Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_  
Group # (Plan, Local or Policy #) \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relation \_\_\_\_\_  
Insured's Birthdate / / Insured's SS# \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

*Secondary Dental Insurance*  
Name of Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_  
Group # (Plan, Local or Policy #) \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relation \_\_\_\_\_  
Insured's Birthdate / / Insured's SS# \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

## Emergency Contact

In the event of an emergency is there a person you would like us to contact?  
Name of Contact \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home # \_\_\_\_\_  
Work # \_\_\_\_\_ Ext. \_\_\_\_\_