



CHDA

Cherry Hills
Dental Associates, P.C.

FAMILY COSMETIC AND
IMPLANT DENTISTRY

Michael J. Schwab, D.M.D.

John D. Pfalzgraf, D.D.S.

Bryan D. Gibbs, D.D.S.

James F. Kinkade, D.D.S.

LAST NAME _____ FIRST _____ INITIAL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SEX _____ SOCIAL SECURITY _____

PERSON RESPONSIBLE FOR ACCOUNT _____

HOME PHONE _____ WORK PHONE _____

CELL _____ MARITAL STATUS _____

INSURANCE INFORMATION

PRIMARY INS. _____ ID NUMBER _____

GROUP NUMBER _____ EMPLOYER _____

NAME OF EMPLOYEE _____ BIRTHDATE _____

INSURANCE ADDRESS _____

SECOND INSURANCE COMPANY

INSURANCE NAME _____ ID NUMBER _____

GROUP NUMBER _____ EMPLOYER _____

NAME OF EMPLOYEE _____ BIRTHDATE _____

INSURANCE ADDRESS _____

DEPENDENTS UNDER INSURANCE

LAST DENTAL VISIT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:

TO THE BEST OF MY KNOWLEDGE THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES. I ALSO UNDERSTAND THAT CHERRY HILLS DENTAL SUBMITS CLAIMS AS A COURTESY, AND I WILL BE RESPONSIBLE FOR PAYMENT IF I DO NOT HAVE MY CORRECT INSURANCE WITH ME.

_____ DATE _____

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