A1 Dental Care
7780 S. Jones Blvd, Ste #101
Las Vegas, Nevada 89139

Dr. Traci Doan, DDS

CHART # ___________

Primary Dental Insurance

Name of Insured Last ____________________ First ____________________ Initial ______

Soc. Sec. #____________ D.O.B ________ Relationship to patient____________

Address (if different from patient's) ____________________ Phone (__)__________

City ___________________________ State ____________ Zip______________

Employed by ______________________________ Occupation________________

Employers Address ____________________________ Work Phone#(__)__________

Insurance Company___________________________ Phone#________________

Address __________________ City _______________ State______ Zip_________

Secondary Dental Insurance

Name of Insured Last ____________________ First ____________________ Initial ______

Soc. Sec. #____________ D.O.B ________ Relationship to patient____________

Address (if different from patient's) ____________________ Phone (__)__________

City ___________________________ State ____________ Zip______________

Employed by ______________________________ Occupation________________

Employers Address ____________________________ Work Phone#(__)__________

Insurance Company___________________________ Phone#________________

Address __________________ City _______________ State______ Zip_________

Assignment of benefits: I hereby authorize and request my insurance company to pay directly to Premier Dental Care the amount due on my claim for services rendered to my dependant or me. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference; and if the nature of the liability were such that it is not covered by the policy, I will be responsible to A1 Dental Care for payment of the entire bill.

Signed: ______________________________ Date: ________________