Garner Family Dentistry, LLC
Cynthia L. Garner, D.D.S

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Patient Name ______________________________________Patient DOB: _____________________
Address__________________________ City______________________ State_______ Zip________
Phone: _______________ Cell:__________________ Patient Relationship to Insured ____________

Primary Dental Insurance:

Dental Insurance Company: ______________________________________ Phone: _______________
Address________________________________ City_____________________ State____ Zip_______

Subscriber Name: __________________________________ Subscriber DOB:___________________
Address ___________________________________City _________________ State ______Zip_____
Phone: __________________ Cell: ________________ Subscriber SS #_______________________
Subscriber ID # ________________________ Eligibility Date Group # _______________________

Is insurance a self-plan? Yes ______ No _______
Is insurance through employment? Yes ____No ______ If yes please provide the following:
Employer: __________________________________ Phone: _________________
Address________________________________ City_____________________ State_______ Zip______

Secondary Dental Insurance: (If applicable)

Dental Insurance Company:__________________________________ Phone:__________________
Address _____________________________ City _______________________State _____Zip____

Subscriber Name _______________________________ Subscriber DOB_______________________
Address ___________________________________City _____________________ State _____Zip ____
Phone: _____________________________ Cell: __________________
Subscriber SS #_______________________ Subscriber ID # __________________________

Is insurance a self-plan? Yes _______ No ________

Is insurance through employment? Yes _______No ______ If yes provide the following information:
Employer ___________________________________ Phone: ________________________________
Address ________________________________ City___________________ State______ Zip _____