



### Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

SSN# \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Email \_\_\_\_\_ Referred by: \_\_\_\_\_

### Emergency Contact Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Emergency Contact Information

Insurance Co. \_\_\_\_\_ Employer \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber ID \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber DOB \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Do you have Secondary Insurance Information? \_\_\_\_\_

### Office and Financial Policies

I have read and understand the Office and Financial Policies. I have had the opportunity to ask any question and I agree to comply with the policies. I certify to the best of my knowledge that all information I have been provided is accurate and true. By signing this agreement, you agree to pay for any cost we estimate due to us at the time of services being provided.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Dr. Joshua Kennedy, D.M.D**

1842 W. Northern Lights Blvd.  
Anchorage, AK 99517

(907) 272-6122

[www.turnagaidental.com](http://www.turnagaidental.com)