



Dr. Will Ellingson, DMD
1030 E. 11400 S. Suite 2
Sandy, Utah 84094
801-255-2100

Welcome to our office!

PATIENT INFORMATION

Full Name: _____ Date: _____
Last First M.I.

Preferred Name: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐ Male ☐ Female

Address: _____
Street Address City State Zip

Home Phone: _____ Cell Number: _____ Email Address: _____

Birthday: ____/____/____ Social Security#: _____ Drivers License#: _____

Employer: _____ Employer Address: _____
Street City State Zip

Emergency Contact Name: _____ Relation: _____ Number: _____

Other family members seen by us: _____ Who can we thank for referring you? _____

SPOUSE INFORMATION

His/Her Name: _____

Birthday: ____/____/____ SSN: _____

Employer: _____

Phone: _____ Email: _____

RESPONSIBLE PARTY FOR ACCOUNT

Name: _____ Relation: _____

Address: _____
Street City State Zip

Phone: _____ SSN: _____

Employer: _____

Primary Dental Insurance

Insurance Co. Name: _____ Phone: _____ Group # (Plan, Local, or Policy#) _____

Insurance Address: _____
Street City State Zip

Insured Name: _____ Insured SSN: _____ Insured Birthday: ____/____/____ Relation: _____

Insured Employer: _____ Employer Address: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: _____ Group # (Plan, Local, or Policy#) _____

Insurance Address: _____
Street City State Zip

Insured Name: _____ Insured SSN: _____ Insured Birthday: ____/____/____ Relation: _____

Insured Employer: _____ Employer Address: _____