

**Dr. James Lapierre DDS**

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| First Name: Last Name: |
| Address: |
| Phone Number: Email:  Contact Method For Appointment Reminders: Text Email Both |
| Birthdate: Social Security Number: |
| **Insurance Information:** |
| Name of Insured: Birthdate of Insured: |
| Insured Member ID/Social Security Number: |
| Group Number: |
| Employer: |
| Insurance Company: |
| Insurance Company Address: |
| **Secondary Insurance Information (if applicable):** |
| Name of Insured: |
| Insured Member ID/Social Security Number: |
| Employer: |
| Insurance Company: |
| Insurance Company Address: |
| Group Number: |