

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out
this form completely (in ink). If you have any questions or need
assistance, please ask us - we will be happy to help.

Patient # _____

Soc. Sec. # _____

Date _____

Home Phone _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____

Address _____ City _____ State _____ zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School / College _____ City _____ State _____ full time part time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Name of General Dentist _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____

Responsible Party

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ E-Mail Address _____

Employer _____ Work Phone _____ SSN # _____

Is this Person Currently a Patient in our office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ ZIP/Post. Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ ZIP/Post. Code _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ ZIP/Post. Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ ZIP/Post. Code _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____