

Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Date _____

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Patient's Social Security # _____
Person to Contact in Case of Emergency _____ Phone _____
Cell Phone _____ e-mail address _____
Preferred way to be contacted: Home # Cell # e-mail Work #

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Insurance ID # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY (If Different From Insured)

Name of Person Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone _____
Social Security # _____ Birthdate _____ Work Phone _____
Employer _____
Currently a Patient in our Office? Yes No

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____

OVER