



Welcome

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ Soc. Sec. No. _____
First MI Last
Address _____ City _____ State _____ Zip _____
Birthdate _____ Home Phone # _____ Work Phone # _____
Do you prefer to receive calls at: Home Work Either
Are you: Minor Married Divorced Widowed Single Separated
Your or your parent's employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse's or parent's name _____ Workplace _____ Work Phone # _____
If you are a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____
Relationship to patient _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work Phone # _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____
DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

CONFIDENTIAL