

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: _____ Social Security Number: _____ - _____ - _____ Email Address: _____
Name: Mr Mrs Ms Dr Last _____ First _____ Initial _____ Sr Jr
Address _____
City _____ State _____ Zip Code _____
Home Phone () _____ Cell Phone () _____
Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced
Patient Employed By _____ Occupation _____
Business Address _____ Business Phone () _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone () _____

Primary Insurance

Person Responsible for Account: Last _____ First _____ Initial _____
Relation to Patient _____ Birthdate _____ Social Security Number _____ - _____ - _____
Address (If different from patient's) _____ Phone () _____
City _____ State _____ Zip Code _____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Business Phone () _____
Insurance Company _____
Contact # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? YES NO
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (If different from patient's) _____ Phone () _____
City _____ State _____ Zip Code _____
Subscriber Employed By _____ Occupation _____
Business Address _____ Business Phone () _____
Insurance Company _____ Social Security Number _____ - _____ - _____
Contact # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____