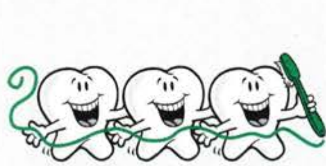
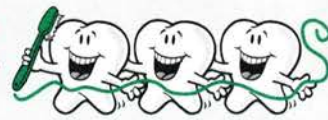


Welcome



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 questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date ______ Home Phone (____) ______ Alt. Phone (____) ______

Name ______ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # ______

Address ______ E-mail ______

City ______ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______ Occupation ______

Employer/School Address ______ Employer/School Phone (____) ______

Whom may we thank for referring you? ______

In case of emergency who should be notified? ______ Phone (____) ______

Primary Insurance

Person Responsible for Account ______ (Last Name / First Name / Middle Initial)

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone (____) ______

Insurance Company ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______ Birthdate ______ Relation to Patient ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Subscriber Employed by ______ Business Phone (____) ______

Insurance Company ______ Soc. Sec. # ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

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Please Complete Both Sides