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

Name: _____ Prefers to be called: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Sex: M F Social Security #: _____ Birthdate: _____

Home #: _____ Cell #: _____ Marital Status: _____

Work #: _____ Ext: _____ Occupation: _____

Which number do you prefer we use to contact you? ____

Employer: _____

Employer Address: _____

Responsible Party

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

_____ Email: _____

Birthdate: _____ Social Security #: _____ Home phone #: _____

Address: _____ Cell phone #: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work phone #: _____ Ext. _____

Primary Insurance

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____ Social Security #: _____ Work phone #: _____

Employer: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____ Social Security #: _____ Work phone #: _____

Employer: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Referral Information

How did you find out about our office? _____