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 (_____) _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Child ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

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

Preferred Confirmation Number _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

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

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____ Insurance Phone (_____) _____

Group # _____ Member ID # _____

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 _____

Employer _____ Business Phone (_____) _____

Insurance Company _____ Soc. Sec. # _____

Group # _____

Please Complete Other Side