

# Welcome

– Please fill out this form so that we may provide you with the best possible care.

We need to have adequate information to reach you if need be and to submit to your dental insurance for you. . All information is confidential. If you have any questions or need assistance please ask us and we will be happy to help.

## Patient Information

Date \_\_\_\_\_

Circle One: Male Female

Name of Minor Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Where does the child go to school \_\_\_\_\_

## Financial Responsible Party

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## Dental Insurance Information (We will photocopy your I.D. Card for you.)

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Date insurance went into effect \_\_\_\_\_

## Secondary Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Date insurance went into effect \_\_\_\_\_