

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: Mr. Mrs. Miss Ms. Dr. Circle One: Single Married Divorced Widowed

Circle One: Male Female

Name _____ Date of Birth _____

How would you like us to address you _____

Mailing Address _____ City _____

State _____ Zip Code _____ Home Phone _____

Patient's Employer _____ Work Phone _____

Spouse Name _____ Work Phone _____

Spouse's Employer _____

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 _____

Student Status

Are you a full-time student? _____

If so list the school name _____ City _____ State _____

Whom is responsible for the account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

HomePhone _____ Work Phone _____