Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

PATIENT INFORMATION (Confidential)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ STATE/PROV. _____ ZIP/POST. CODE _____

Patient # _____ Soc. Sec. # _____ Date _____

Email _____ Cell Phone _____

Address _____

Check Appropriate Box: ❑ **Minor** ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**

If Student, Name of School/College _____ City _____ STATE/PROV. _____ ❑ **Full Time** ❑ **Part Time**

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ STATE/PROV. _____ ZIP/POST. CODE _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____

Person to Contact in Case of Emergency _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this person currently a patient in our office? ❑ **YES** ❑ **NO**

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❑ **Cash** ❑ **Personal Check** ❑ **Credit Card** ❑ **Visa** ❑ **MasterCard** ❑ **I wish to discuss the office's payment policy.**

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ STATE/PROV. _____ ZIP/POST. CODE _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ STATE/PROV. _____ ZIP/POST. CODE _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ **YES** ❑ **NO** **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ STATE/PROV. _____ ZIP/POST. CODE _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ STATE/PROV. _____ ZIP/POST. CODE _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Over Please