Welcome

Thank you for selecting out 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#:
SS#:
Date:

Patient Information (confidential)

Name: Birth date: Home Phone:
Address: City: State: Zip:
Email: Cell Phone:
Check Appropriate Box: ☑ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College: City: State: ☑ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer: Work Phone:
Business Address: City: State: Zip:
Spouse or Parent/Guardian's Name: Employer: Work Phone:
Whom may we thank for referring you?
Person to contact in case of emergency: Phone:

Responsible Party

Name of Person Responsible for this Account: Relationship to Patient:
Address: Home Phone:
Email: Cell Phone:
Driver's License # Birth date: 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:
Birth date: SS#: Date Employed:
Name of Employer: Union or Local #: Work Phone:
Address of Employer: City: State: Zip:
Insurance Company: Group #: Policy/ID #:
Ins. Co. Address: City: State: Zip:
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:
Birth date: SS#: Date Employed:
Name of Employer : Union or Local #: Work Phone:
Address of Employer: City: State: Zip:
Insurance Company: Group #: Policy/ID #:
Ins. Co. Address: City: State: Zip:
How much is your deductible? How much have you used? Max. annual benefit: