Welcome!

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information:

Today's Date: ____________________

Patient Name: ____________________ Social Security: ____________________

Address: ____________________

City: ____________________ State: ________Zip: ____________________

Home Number: ____________________Cell Phone Number: ____________________

Work Number: ____________________E-mail Address: ____________________

Can we use your e-mail and cell phone for electronic correspondence?
E-mail: Yes __________ **No** __________ **Text Messages: Yes** __________ **No** __________

Sex: Male Female Date of Birth: ____________ Age:________ Married: _____ Divorced: _____Single: ________

Employer/School ____________________ Occupation ____________________

Employer/School Phone: ____________________ Whom may we thank for referring you? ____________________

Emergency Contact: ____________________ Phone: ______________Relationship to patient: ______________

Primary Insurance:

Person Responsible for Account ____________________ Social Security: ____________________

Relationship to patient: ____________________ Date of Birth: ____________________

Address (If different from patient's): ____________________

City: ____________________ State: ________Zip: ____________________

Person Responsible Employed by: ____________________Occupation: ____________________

Insurance Company: ____________________ Insurance Co Phone Number: ____________________

Insurance Company Address: ____________________

Plan Group #: ____________________ Subscriber ID (If different than social): ____________________

Names of other dependants covered under this plan: ____________________

Additional Insurance:

Is patient covered by additional insurance? Yes: __________ No: __________

Subscriber Name: ____________________ Social Security: ____________________

Relationship to patient: ____________________ Date of Birth: ____________________

Address (If different from patient's): ____________________

City: ____________________ State: ________Zip: ____________________

Person Responsible Employed by: ____________________Occupation: ____________________

Insurance Company: ____________________ Insurance Co Phone Number: ____________________

Insurance Company Address: ____________________

Plan Group #: ____________________ Subscriber ID (If different than social): ____________________

Names of other dependants covered under this plan: ____________________