WELCOME

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental health care 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.

Date_____

Patient Information (Confidential)

Name_____Birthdate_____

Address_____City_____State_____Zip_____

Social Security Number_____

Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated ❒ Partner

Please fill in all contact information below and check box of preferred contact

❒ Home Phone (_____)_____ ❒ Cell Phone (_____)_____

❒ Work Phone (_____)_____ ❒ Email _____

If Student, Name of School/College_____ Full-time Part-time

Patient's or Parent's Employer_____ Work Phone (_____)_____

Business Address_____ City_____ State____Zp_____

Spouse or Parent's Name _____Employer _____Phone_____

Whom may we thank for referring you?_____

Person to contact in case of an emergency_____Phone (_____)_____

Other family members seen here_____

Responsible party

Name of person responsible for this account_____Relationship to Patient_____

Address_____City_____State___Zip_____Phone_____

Driver's License #_____ Birthdate_____ Financial Institution_____

Employer_____Work Phone (_____)_____SSN_____

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

Payment is due at the time of service. For your convenience, we offer the following methods of payment.

❒ Cash ❒ Personal Check ❒ Debit Card ❒ Visa ❒ Master Card ❒ I wish to discuss financing options

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN or ID#_____

Name of employer_____Work Number_____

Insurance Company_____ Group #_____ ID#_____

Insurance Company Address_____ City_____ State___Zip_____

How much is your deductible?_____Annual Benefit amount?_____ Benefit used_____