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. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient Information

Today's Date_____

Name_____ Nickname:_____ Date of Birth _____ Sex_____

Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail_____

Check appropriate box: Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other [ ]

Referred to our office by_____

Responsible Party Information

Name of Responsible Party (guardian)_____ Social Security #_____

Address (if different than patient)_____ City, State, Zip_____

Occupation_____ Employer_____

Employer's Address_____ Phone_____

How would you like to pay for your portion of the provided services? Cash [ ] Check [ ] Credit Card [ ] Other [ ]

Responsible Party's Spouse

Name of Responsible Party's Spouse_____ Social Security#_____

Address (if different than patient)_____ City, State, Zip_____

Occupation_____ Employer_____

Employer's Address_____ Phone_____

Dental Insurance Information

Insurance Company_____ Insured Name_____

Insured DOB_____ Relationship to Patient_____

Subscriber #_____ Group #_____ Employer_____

Insurance Co. Address_____ Phone_____

Secondary Dental Insurance Information

Insurance Company_____ Insured Name_____

Insured DOB_____ Relationship to Patient_____

Subscriber #_____ Group #_____ Employer_____

Insurance Co. Address_____ Phone_____