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 your entire dental healthcare needs, please fill out this form completely. If you have questions, or need assistance, please ask us – we will be happy to help.

Patient Information (confidential) Date_____

Name_____Birthdate_____
(first) (middle) (last)
SS#_____Preferred Name_____
Gender_____Marital Status_____
Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____Ext_____Mobile_____
Place of Employment_____
Emergency Contact Person_____Phone_____
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Insurance Information (We need a copy of your card or insurance claim form)

Name of insured_____Relationship to patient_____
SS#_____(insured) Birthdate_____

Address (if different than above)_____
Name of Employer_____
Address of Employer_____
Insurance Company_____Group #_____
Insurance Company Address_____
Insurance Company Phone_____
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Responsible Party

Name of person responsible for the account_____
Relationship to Patient_____
Is this person currently being seen in our office?_____
Address_____City_____State_____Zip_____
Phone_____

How did you hear about our office_____

Referring Patient_____Referring Doctor_____

The above information is true to the best of my knowledge._____
Signature