Welcome

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

ACCOUNT # _____
OFFICE USE ONLY

☐ Mr. ☐ Mrs. ☐ Ms. **PATIENT INFORMATION** Date

Name _____
Last First Middle

Address: _____ City: _____ ST: _____ Zip: _____

Phone #( ) _____ S.S. # _____ DL# _____

Birthdate: _____ Sex: _____ Referred by: _____

Employer: _____ Work phone # ( ) _____

If patient has ever been known under another name, list _____

Spouse Name: _____ Spouse Employer: _____ PHONE _____

Please give full name of person to contact in case of emergency, preferably the name of the person who does not live with you.

Name: _____ Relationship to Patient _____

Address: _____ Phone # ( ) _____

IF THE PATIENT IS A MINOR CHILD, WHO IS THE RESPONSIBLE PARENT OR GUARDIAN FOR THIS ACCOUNT

Name _____
Last First Middle

Address: _____ City: _____ ST: _____ Zip: _____

Phone #( ) _____ S.S. # _____ DL# _____

Employer: _____ Work phone # ( ) _____

Occupation: _____ Relationship to Patient: _____ Birthdate _____

INSURANCE INFORMATION

INFORMATION MUST BE COMPLETED FOR INSURANCE COMPANY TO BE BILLED

PRIMARY INSURANCE INFORMATION

Company _____ Phone # _____

Address _____

Subscriber _____

Subscriber Employer _____ Effective Date _____

ID # _____ Birthdate: ___/___/___ Group # _____ CoPay _____

SECONDARY INSURANCE INFORMATION

Company _____ Phone # _____

Address _____

Subscriber _____

Subscriber Employer _____ Effective Date _____

ID # _____ Birthdate: ___/___/___ Group # _____ CoPay _____

FAMILY MEMBERS

		Birthdate	HOME #	WORK #
1. Self				
2. Spouse				
			SCHOOL NAME	SCHOOL #
3. Child				
4. Child				
5. Child				

Signature _____

THERE WILL BE A $60 FEE FOR MISSED APPOINTMENTS