

# Welcome

Thank you for choosing the dental healthcare team of Legacy Dental Group.  
We will strive to provide you with the best possible dental care possible.  
To help us meet all of your dental healthcare needs,  
please completely fill out this form in ink.  
If you have any questions or need assistance, please ask us- we are here to help.

## Patient Information (CONFIDENTIAL)

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_-\_\_\_\_-\_\_\_\_

(Please check one) Patient is:  Minor  Single  Married  Divorced  Separated

Residential Address \_\_\_\_\_ Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employer Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_

(if different from home address) Mailing Address \_\_\_\_\_

\_\_\_\_\_ If Patient is a Full-Time Student, Name of School/College: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Person to Contact in Case of an Emergency \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to patient \_\_\_\_\_

## Responsible Party

Responsible Party Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Driver's Lic. # \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Soc. Sec.# \_\_\_\_-\_\_\_\_-\_\_\_\_

Spouse's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Soc. Sec.# \_\_\_\_-\_\_\_\_-\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Is the responsible party currently a patient of this office? Y/N

## Insurance Information

Insurance Carrier/Plan \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber ID. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_-\_\_\_\_-\_\_\_\_ Employer \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_ Annual Deductible \$ \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ - \_\_\_\_\_ Maximum Annual Benefit \$ \_\_\_\_\_

Has your deductible been met for the current benefit year? Y/N

DO YOU HAVE ANY ADDITIONAL OR SECONDARY INSURANCE COVERAGE? IF YES, COMPLETE BELOW

Insurance Carrier/Plan \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber ID. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_-\_\_\_\_-\_\_\_\_ Employer \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_ Annual Deductible \$ \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ - \_\_\_\_\_ Maximum Annual Benefit \$ \_\_\_\_\_

Has your deductible been met for the current benefit year? Y/N

Have you been seen in another dental office this year? Y/N If yes, were X-rays taken? Y/N

How did you hear about Legacy Dental Group? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_