

# WELCOME

The benefits of a happy, healthy smile are immeasurable!  
Our goal is to help you reach and maintain optimal oral health.  
Please fill out this form completely.

## ABOUT YOU

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

Name: \_\_\_\_\_  
Last First Mi Mr Mrs Ms Dr

Address: \_\_\_\_\_  
Apt

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

Cell#: ( ) \_\_\_\_\_ - \_\_\_\_\_ Hm#: ( ) \_\_\_\_\_ - \_\_\_\_\_

Wk#: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Where & when are the best times to reach you?: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ DL#: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Whom may we thank for referring you?: \_\_\_\_\_

Other family member seen by us: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

### SPOUSE / PARTNER INFORMATION

Name: \_\_\_\_\_  
Last First Mi

Employer: \_\_\_\_\_

Wk #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Hm#: ( ) \_\_\_\_\_ - \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL #: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Last First Mi

Wk #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Hm#: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

## INSURANCE

Do you currently have Dental Insurance? **Y N**  
(Circle)

Insurance carrier: \_\_\_\_\_

Insurance carrier phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Group # (Plan, or Policy #): \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is subscriber insured by their employer? **Y N**  
(Circle)

Subscriber's employee issuing dental insurance: \_\_\_\_\_

### SECONDARY INSURANCE

Do you currently have a secondary dental insurance? **Y N**  
(Circle)

Insurance carrier: \_\_\_\_\_

Insurance carrier phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Group # (Plan, or Policy #): \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber's birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is subscriber insured by their employer? **Y N**  
(Circle)

Subscriber's employee issuing dental insurance: \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

SELF or OTHER (see below)  
(Circle)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Last First Mi

Wk #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Hm#: ( ) \_\_\_\_\_ - \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL #: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Billing Address: \_\_\_\_\_

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

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.