WELCOME TO OUR OFFICE

1. About You

Today's Date:_____/_____/_________ File #:___________

Patient Name: ________________________________

LAST FIRST MI

What You Prefer To Be Called:_____________ Male / Female

Birthdate:____/____/_____Age:_____ SS#____________

Mailing Address:________________________________

City________________State_________Zip________

Home Phone #: (_________)______________________

Work Phone #: (_________)______________________

Cell Phone #: (_________)______________________

E-Mail Address:________________________________

Referred By:____________________________________

Employer:_________________How long?________

Employer's Address:______________________________

City:________________State_________Zip________

Occupation:_____________________________________

Status:__Single__Married__Divorced__Separated__Widowed

Spouse's Name:__________________________________

2. Insurance Information

PRIMARY DENTAL INSURANCE

Company Name:___________________________

Address:________________________________

City______________State_______Zip_______

Phone #: (_______)______________________

Insured's ID#/SS#:______________________

Group #(Plan, Local, Policy#)____________

Insured's Name:_________________________

Relation:__________Date of Birth:___/___/___

Insured's Employer:______________________

SECONDARY DENTAL INSURANCE

Company Name: __________________________

Address:________________________________

City:______________State_______Zip_______

Phone #: (_______)______________________

Insured's ID#/SS#:______________________

Group # (Plan, Local, Policy #)__________

Insured's Name:_________________________

Relation:__________Date of Birth:___/___/___

Insured's Employer:______________________

3. Account Information

Person Ultimately Responsible for Account

Name:_________________________________

Relation:______________________________

Billing Address:________________________

City______________State________Zip________

SS#:__________________________________

Drivers License #:______________________

Work Phone #:(_______)__________________

Payment Method: _____Cash____Check____ Credit Card

Credit Card # _______________________ ____/____

I hereby authorize assignment of my insurance rights & benefits directly to the provider for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges. Our policy requires payment for all services at the time of visit. If account is not paid within 90 days of date of service, you will be responsible for interest fees, billing charges, collection agency fees, & any other expenses incurred in collecting your account.

Signature:_________________________________Date:______

4. In Event of Emergency

Whom should we contact?_________________

Relation:_______________________________

Home Phone #:(_____)____________________

Work Phone #:(_____)____________________

Cell Phone #: (_____)____________________

Who is your Medical Doctor?_______________

Medical Doctor's Phone #: (____)__________