

# Welcome To Our Practice

Date \_\_\_\_\_

**Patient** (Mr., Mrs., Ms., Dr.) \_\_\_\_\_

Male  Female      Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_

Mailing \_\_\_\_\_ Street \_\_\_\_\_

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

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Cell # \_\_\_\_\_

Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_

Which phone # is better to reach you during the day?  Home  Work  Cellular  Email \_\_\_\_\_

Have you ever been a patient of our practice?  Yes  No

**Who will be responsible for your account?**  Self  Spouse  Father  Mother

**Marital Status?**  Married  Divorced  Legally Separated  Widowed  Single

Name \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_

Mailing \_\_\_\_\_ Street \_\_\_\_\_

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

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_

Cell # \_\_\_\_\_ Employer \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Whom may we thank for referring you to our office?

\_\_\_\_\_

Dentist \_\_\_\_\_

Medical Doctor \_\_\_\_\_

Name of relative or friend not living with you.

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Relation \_\_\_\_\_

## Insurance Information

**Patient:** Student:  Full Time  Part Time School Name/Address \_\_\_\_\_

Marital Status:  Married  Divorced  Legally Separated  Widowed  Single

Employed:  Full Time  Part Time  Retired

**Primary Dental Insurance Company**

Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ # of Years Employed \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Party \_\_\_\_\_ Relation \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_

Street \_\_\_\_\_

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

Home # \_\_\_\_\_ SS# \_\_\_\_\_

**Primary Medical Insurance Company**

Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ # of Years Employed \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Party \_\_\_\_\_ Relation \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_

Street \_\_\_\_\_

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

Home # \_\_\_\_\_ SS# \_\_\_\_\_

I attest these are the only insurance policies I am aware of. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize and direct payment of any benefit otherwise payable to me directly to the treating physician or practice.

Policy Holder's Signature \_\_\_\_\_