Welcome To Our Practice

Date:_____

Patient: First Name_____ M.I.____ Last Name_____ Nickname_____

Sex: ☐ Male ☐ Female Date of Birth_____ Age____ Soc. Sec.#_____ Email (optional)_____

Street_____ City_____ State_____ Zip_____

Home Tel.# (____) _____ Business Tel.# (____) _____ Ext._____ Employer_____

Dentist_____ Medical Doctor_____ Referred By _____

Driver's Lic. #_____ Nearest relative not living with you_____ Tel. # (____) _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Method of Personal Payment: ☐ Cash ☐ Check ☐ Credit Card

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other_____
(If self, skip to next paragraph)

Name_____ Soc. Sec.#_____ Home Tel. (____) _____

Street_____ City_____ State_____ Zip_____

Employer_____ Tel. (____) _____

Spouse or other guarantor information (if different from above)

Name_____ Relation_____ Soc. Sec.#_____ Home Tel. (____) _____

Street_____ City_____ State_____ Zip_____

Employer_____ Tel. (____) _____

INSURANCE INFORMATION

Patient: Student: Full Time ☐ Part Time ☐ Not ☐ School Name/Address_____

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ _____

Employed: Full Time ☐ Part Time ☐ Retired ☐ Not ☐ Do you belong to a PPO or HMO? Yes ☐ No ☐

PRIMARY DENTAL INSURANCE COMPANY

Employer_____

Bus. Address_____

Bus. Tel.# (____) _____ Plan_____

Ins. Co. Name_____

Address_____

_____ Tel.# (____) _____

Group #_____ **Group Name**_____

Insured Party_____ Relation_____

Sex: ☐ M ☐ F Date of Birth_____

Street_____

City, State, Zip_____

Tel.# (____) _____ S.S.#_____

I.D.#_____

PRIMARY MEDICAL INSURANCE COMPANY

Employer_____

Bus. Address_____

Bus. Tel.# (____) _____ Plan_____

Ins. Co. Name_____

Address_____

_____ Tel.# (____) _____

Group #_____ **Group Name**_____

Insured Party_____ Relation_____

Sex: ☐ M ☐ F Date of Birth_____

Street_____

City, State, Zip_____

Tel.# (____) _____ S.S.#_____

I.D.#_____

SECONDARY DENTAL INSURANCE COMPANY

Employer_____

Bus. Address_____

Bus. Tel.# (____) _____ Plan_____

Ins. Co. Name_____

Address_____

_____ Tel.# (____) _____

Group #_____ **Group Name**_____

Insured Party_____ Relation_____

Sex: ☐ M ☐ F Date of Birth_____

Street_____

City, State, Zip_____

Tel.# (____) _____ S.S.#_____

I.D.#_____

SECONDARY MEDICAL INSURANCE COMPANY

Employer_____

Bus. Address_____

Bus. Tel.# (____) _____ Plan_____

Ins. Co. Name_____

Address_____

_____ Tel.# (____) _____

Group #_____ **Group Name**_____

Insured Party_____ Relation_____

Sex: ☐ M ☐ F Date of Birth_____

Street_____

City, State, Zip_____

Tel.# (____) _____ S.S.#_____

I.D.#_____