GETTING TO KNOW YOU ....

Last Name: _____ First Name: _____ Preferred Name: _____

Mailing Address: _____

City/Zip: _____

Date of Birth: _____

Phone Numbers: Home ( )_____

Work ( )_____

Cell ( )_____

Email Address:_____

Emergency Contact Name: _____ Phone Number: _____

Employer Name: _____

Employer Address: _____

City/Zip: _____

Do you have dental insurance? Yes No

If Yes, then please fill out the following:

Insurance Company: _____

Subscribers Name: _____

Relationship to You: _____

Subscriber's Social Security or ID #: _____ Date of Birth: _____

Do you have secondary dental insurance? Yes No

If Yes, then please fill out the following:

Insurance Company: _____

Subscribers Name: _____

Relationship to You: _____

Subscriber's Social Security or ID #: _____ Date of Birth: _____

*Please list authorized individuals who can obtain information regarding your account and treatment in our office:

_____