Welcome to our Practice

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Patients Name_____ How do you prefer to be addressed? _____

Mailing Address_____ City_____ State_____ Zip_____

E-mail _____ Best time and place to reach you _____

Sex: M F Age: _____ Birth Date: _____ Single Married Widow Separated Divorced SS#_____

Home Phone Number: _____Work Phone Number: _____ Cell Phone Number _____

Occupation: _____Employer: _____

Employer's Address: _____City _____State_____ Zip _____

If Student, name of School/College: _____City _____State_____ PT Full

Whom may we thank for referring you to our office: _____

If the person responsible for this account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party _____Relationship to Patient_____

Mailing Address _____ City_____ State_____ Zip_____

Sex: M F Age: _____ Birth date: _____ Single Married Widow Separated Divorced SS#_____

Home Phone Number: _____Work Phone Number: _____ Cell Phone Number: _____

Occupation: _____Employer: _____

Employer's Address: _____ City _____State _____ Zip _____

INSURANCE INFORMATION

Policy Holders Name _____ DOB _____Relationship to Patient _____ SS#_____

Name of Employer_____ Employee Address _____State_____ Zip _____

Insurance Co._____ Group # _____Address _____

Secondary Insurance Information

Policy Holders Name _____DOB _____Relationship to Patient _____ SS#_____

Name of Employer_____ Employee Address _____State_____ Zip _____

Insurance Co._____ Group # _____Address _____

ASSIGNMENT AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient or guardian