Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us serve your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.
We will be happy to help.

Today's Date: ________________

PATIENT INFORMATION:

Name: ____ DOB: ________________ SSN: ____________________
Preferred Name

Address: ______________________________________ City: ______________________ State: _______ Zip: ________
Apartment

Home phone: ______________________ Work phone: ______________________ Cell phone: ______________________

Email: ____ Employer: ____

Preferred method of contact: ___Home phone ___Work phone ___Cell phone ___Mail ___EMail ___Text message

Gender: ___Male ___Female Maritial status: ____Child/Minor ___Single ___Married ___Divorced ___Widowed

Student? ___Yes ___No Name of school/college: ___________________________ City/State______________________

Emergency Contact: ____ Phone: __________________________

Whom may we thank for referring you to our office? ____

RESPONSIBLE PARTY:

If the person responsible for this patient's 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: _____________________________________ DOB: _____________ SSN: _________________

Address: ___________________________________ City: ______________________ State: _______ Zip: ____________

Home phone: _____________________ Work phone: ______________________ Cell phone: ______________________

Relationship of the patient to the responsible party: ___Spouse ___Child/Minor ___Other

DENTAL INSURANCE INFORMATION:

Primary Ins: Insured's Name: ________________________________ Relationship of patient to insured: ___Self ___Spouse ___Child

Name of employer: ____ Insurance Co phone: __________________

Insurance Co: ____ Group #: ________________ ID #: __________________

Address of Insurance Co: _____________________________ City/State/Zip: ____________________________________

Secondary Ins: Insured's Name: ______________________________ Relationship of patient to insured: ___Self ___Spouse ___Child

Name of employer: ____ Insurance Co phone: __________________

Insurance Co: ____ Group #: ________________ID #: __________________

Address of Insurance Co: _____________________________ City/State/Zip: ____________________________________