Welcome

Date: _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ SSN# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School/College _____ City _____ State _____ ❑ Full Time ❑ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____ Cell Phone _____

Employer Name _____ Work Phone _____ SSN# _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due in full at each appointment.

❑ Cash ❑ Personal Check Credit Card: ❑ VISA ❑ MasterCard ❑ Discover

Dental Insurance

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN# _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ Yes ❑ No ***IF YES, COMPLETE THE FOLLOWING:***

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN# _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

If you are not using your Dental Insurance because your condition is due to a Medical Condition, Motor Vehicle Accident, or Workman's Compensation, please complete below what insurance will be paying for your dental services:

Insurance Co. Name _____ Phone _____

Ins. Co. Address _____ City _____ State _____

Insurance ID or Claim# _____ Group# _____

Date of Accident & State where it occurred _____ if MVA or W/C.

Adjustor's Name & Phone _____ if MVA or W/C.

OVER PLEASE