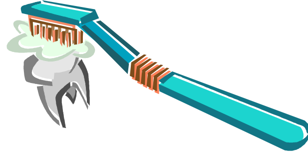

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions, we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name____ Soc. Sec. # _____________________
Last Name *First Name* *Initial*
Address ____
City ____________________________ State _______________ Zip Code ___________________
Home Phone ________________________________ Cell Phone ___________________________
Work Phone ________________________________ E-Mail ______________________________
Sex: ❒ Male ❒ Female ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced
Age ___________ Birth date _____________ Drivers License # __________________________
Notify in case of emergency ______________________________ Relation ___________________
Home Phone __________________ Cell _____________________ Work ___________________
Whom may we thank for referring you? ____

PRIMARY INSURANCE

Person Responsible for Account ____
Last Name *First Name* *Initial*
Relation to Patient __________________ Birth date __________ Soc. Sec. # ________________
Address *(if different from patient)* ____________________________ Home Phone _______________
City _____________________________ State ______________ Zip Code ___________________
Cell Phone ______________________________ E-Mail __________________________________
Person Responsible Employed by _________________________ Occupation ________________
Business Address ___________________________ Business Phone ________________________
Business E-Mail ____
Insurance Company __________________________________ Phone _______________________
Insurance E-Mail ____
Contract # _____________________ Group # _________________ Subscriber # ______________
Name of other dependents under this plan ____