

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all 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.

Patient # _____

SS#/SIN _____

Date _____

Home Phone _____

State/Prov. _____ Zip/P.C. _____

Cell Phone _____

State/Prov. _____

Full Time Part Time

Work Phone _____

State/Prov. _____ Zip/P.C. _____

Work Phone _____

Phone _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____

Address _____ City _____

Email _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____

Patient or Parent/Guardian's Employer _____

Address _____ City _____

Spouse or Parent/Guardian's Name _____ Employer _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____

Responsible Party

Name of Person Responsible for this Account _____

Address _____

Email _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No

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

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____

Birthdate _____ SS#/SIN _____

Name of Employer _____ Union or Local # _____

Address of Employer _____ City _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____

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

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

Name of Insured _____

Birthdate _____ SS#/SIN _____

Name of Employer _____ Union or Local # _____

Address of Employer _____ City _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____

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

Over Please