

# 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 Information (CONFIDENTIAL)

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
If Student, Name of School / College \_\_\_\_\_ City \_\_\_\_\_  
Patient's or Parent's Employer \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_  
Whom May We Thank for Referring You? \_\_\_\_\_  
Person to Contact in Case of Emergency \_\_\_\_\_

Patient # \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_  
Date \_\_\_\_\_  
Home Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ ZIP/Post. Code \_\_\_\_\_  
State/Prov. \_\_\_\_\_  Full Time  Part Time  
Work Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ ZIP/Post. Code \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_  
Address \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
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.

Relationship to Patient \_\_\_\_\_  
Home Phone \_\_\_\_\_

## Insurance Information

Name of Insured \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
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 \_\_\_\_\_

Relationship to Patient \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Work Phone \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy/ID # \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

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

Name of Insured \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
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 \_\_\_\_\_

Relationship to Patient \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Work Phone \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy/ID # \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

Over Please

