WELCOME

Confidential Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information

Name________________________________Preferred Name ___________Date_________

Address______________________________ City____________State____Zip___________

SS #__________________ Home ___________________ Cell ____________________

Occupation___________________________Employer_______________________________

Business Address____

Work Phone___________________________E-Mail Address__________________________

Birthdate_____________ Spouse's or Parent's Name _________________________________

If you are a student, Name of School/College____________________City__________State____

Whom may we thank for referring you to us?____

Person to contact in case of emergency________________________Phone________________

Primary Insurance/Responsible Party

Who is responsible for this account?_____________________Relationship to Patient__________

Address(if different from above)____

Phone_________________Birthdate___________Social Security #_____________________

Employed By_______________________________Work Phone________________________

Insurance Company and Address____

Group #_____________________Subscriber #_____________________________________

Secondary Insurance

Do you have additional insurance coverage? o Yes o No

Subscriber Name __________________________Relationship to Patient_________________

Employed by_____________________________Social Security #______________________

Employer's Phone__________________________Birthdate___________________________

Insurance Company and Address____

Group #_________________________Subscriber #________________________________