Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date_____

Name _____
LAST FIRST MI MR/MRS/MS/DR

I prefer to be called _____ Male Female

Birthdate: ____/____/____ Age: _____ SS# _____

Mailing Address: _____
APT #

_____
CITY STATE ZIP

Email: _____

Home #: _____ Mobile #: _____

Work #: _____ Ext: _____

Prefer to be contacted at: Home/Mobile/Work (please circle)

Employer_____

Occupation: _____

Other family members seen by us: _____

_____

Previous Dentist and or Specialist: _____

Last date visited: _____

How did you hear about our office? _____

Emergency Contact

Name: _____

Relation: _____

Phone #: _____ Please select...

ACCOUNT BILLING INFORMATION

Person responsible for account: _____

Billing Address (if different from above): _____

_____

Phone #:_____

Relation: _____ SS#: _____

Employer: _____

INSURANCE COVERAGE

Primary Dental Coverage: Yes No

Insurance Company Information

Name:_____

Plan Name: _____

Address:_____

Phone #:_____

Insured Information (This is the policy holder/subscriber)

Name:_____

Insured's Birthdate:_____ SSN:_____

Relation To Patient:_____

Member ID:_____

Group #:_____

Employer:_____

Phone #: _____

Secondary Dental Coverage: Yes No

Insurance Company Information

Name:_____

Plan Name: _____

Address:_____

Phone #:_____

Insured Information (This is the policy holder/subscriber)

Name:_____

Insured's Birthdate:_____ SSN:_____

Relation To Patient:_____

Member ID:_____

Group #:_____

Employer:_____

Phone #: _____