

W E L C O M E

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 _____ Home Phone _____
Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

PRIMARY INSURANCE

Person Responsible for Account _____

	<i>Last Name</i>	<i>First Name</i>	<i>Initial</i>
Relation to Patient _____	Birthdate _____	Soc. Sec. # _____	
Address (if different from patient) _____		Home Phone _____	
City _____	State _____	Zip _____	
Cell Phone _____		Email _____	
Person Responsible Employed by _____		Occupation _____	
Business Address _____		Business Phone _____	
Business Email _____			
Insurance Company _____		Phone _____	
Insurance Email _____			
Contract # _____	Group # _____	Subscriber # _____	
Name of other dependents under this plan _____			

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.