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Welcome...

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

1 Patient Information

Today's Date: ___/___/___

Name: _____ (First / Middle / Last) I prefer to be called: _____ (Name) ☐ M ☐ F

Address: _____ (Street / Apt. No. / City / State / Zip Code) Email Address: _____ @ _____

Age: _____ School: _____ _____ (City) Grade: _____ Birth Date: ___/___/___

Hm #: _____ Cell/Other #: _____ Wk #: _____ Ext #: _____

Previous Dentist: _____ Date of Last Dental Care: ___/___/___

Whom may we Thank for referring you? _____ Other family members we see: _____

2 Person Responsible for Account

Name: _____ (First / Middle / Last) Birth Date: ___/___/___ Social Security #: ___-___-___

Relation to Patient: _____

Are you currently: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____ # Years Employed: _____

Residence: _____ (Street / Apt. No. / City / State / Zip Code) How Long? _____

Hm #: _____ Cell/Other #: _____ Wk #: _____ Ext #: _____

Spouse: _____ (First / Middle / Last) Birth Date: ___/___/___ Social Security #: ___-___-___

Employer: _____ (City) , _____ (State) Occupation: _____ # Years Empl.: _____

Active credit card: ☐ *Visa* ☐ *Master Card* ☐ *Discover*

3 Emergency Contacts *(Name of nearest relatives and/or friends not living with you)*

a. Name: _____ (First / Last) Phone #: _____

b. Name: _____ (First / Last) Phone #: _____

4 Primary Insurance Information

Name: _____ (First / Middle / Last) ☐ M ☐ F Birth Date: ___/___/___ S.S. #: ___-___-___

Employer: _____ Employer's Address: _____

Dental Insurance Co.: _____ Phone #: _____

Address: _____ Group #: _____ I.D. #: _____

% of Coverage: _____ % Deductible: _____ Maximum: _____ Benefit Period: ___/___/___

5 Secondary Insurance Information

Name: _____ (First / Middle / Last) ☐ M ☐ F Birth Date: ___/___/___ S.S. #: ___-___-___

Employer: _____ Employer's Address: _____

Dental Insurance Co.: _____ Phone #: _____

Address: _____ Group #: _____ I.D. #: _____

% of Coverage: _____ % Deductible: _____ Maximum: _____ Benefit Period: ___/___/___

I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____ Print Name _____ Date _____