WELCOME

1 ABOUT YOU

Today's Date:_____/_____/_____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❒ Male ❒ Female

Birthdate: ___/___/___ Age: ___ SS#. _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Other Phone #'s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Full-time Student ❒ No ❒ Yes School Name: _____

Spouses's Name: _____

Spouse's Work #: _____ Birthdate: ____/____/____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address _____

_____
CITY STATE ZIP

Phone #: _____

Insured SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name _____

Relation _____ Birthdate: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address _____

_____
CITY STATE ZIP

Phone #: _____

Insured SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name _____

Relation _____ Birthdate: ____/____/____

Insured's Employer: _____

3 ACCOUNT INFO

Person financially responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS#: _____

Work Phone #: _____

_____ I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office) and for any finance charge that may be applied for late balances.
INIT

4 IN THE EVENT OF AN EMERGENCY

Who should be contacted? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____