WELCOME

1 PERSONAL INFO

Today's Date:____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

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

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

Mailing Address:_____

CITY STATE ZIP

Home Phone #: (____)_____

Work Phone #: (____)_____ Ext: _____

Cell Phone #: (____)_____

E-mail Address: _____

Referred By:_____

Employer: _____ How Long?_____

Employer's Address:_____

CITY STATE ZIP

Occupation:_____

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

Spouse's Name: _____

Do you have children? ☐Yes ☐No How many?_____

2 INSURANCE INFO

Primary Dental Insurance

Ins. Co. Name: _____

Address:_____

CITY STATE ZIP

Phone #: (____)_____

Insured's ID #:_____

SS #:_____

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

Insured's Name:_____

Relation:_____ Date of Birth:___/___/___

Insured's Employer: _____

Secondary Dental Insurance

Ins. Co. Name: _____

Address:_____

CITY STATE ZIP

Phone #: (____)_____

Insured's ID #:_____

SS #:_____

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

Insured's Name:_____

Relation:_____ Date of Birth:___/___/___

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address:_____

CITY STATE ZIP

SS #:_____

Drivers License #:_____

Work Phone #: (____)_____

Payment method: ☐ Cash ☐Check

☐ Credit Card - Enter card # above (if accepted)

_____ Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4 EMERGENCY CONTACT INFO

Whom should we contact? _____

Relation:_____

Home Phone #: (____)_____

Work Phone #: (____)_____

Cell Phone #: (____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone #: (____)_____

PLEASE CONTINUE ON BACK

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