Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

SS#/SIN _____
Date _____
Patient's Sex ❑ *F* ❑ *M*

Patient Information (CONFIDENTIAL)

Name _____ *Birthdate* _____ *Home Phone* _____
Address _____ *City* _____ *State* _____ *Zip* _____
Email _____ *Cell Phone* _____
Do you prefer to receive calls at your: ❑ *Home* ❑ *Work* ❑ *Cell Phone*
Check Appropriate Box: ❑ *Minor* ❑ *Single* ❑ *Married* ❑ *Divorced* ❑ *Widowed* ❑ *Separated*
If Student, Name of School/College _____ *City* _____ *State* ____ ❑ *Full Time* ❑ *Part Time*
Patient or Parent/Guardian's Employer _____ *Work Phone* _____
Business Address _____ *City* _____ *State* _____ *Zip* _____
Spouse or Parent/Guardian's Name _____ *Employer* _____ *Work Phone* _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ *Phone* _____

OUR OFFICE IS CAPABLE OF CONTACTING YOU BY TELEPHONE, EMAIL OR TEXT MESSAGE.
(For Appointment Reminders, etc.)
Please indicate which method of contact is most convenient for you:

_____*telephone* _____*email* _____*text message*

Responsible Party (If different from above)

Name of Person Responsible for this Account _____ *Relationship to Patient* _____
Address _____ *Birthdate* _____ *Home Phone* _____
Email _____ *Cell Phone* _____
Employer _____ *Work Phone* _____ *SS#/SIN* _____
Is this Person Currently a Patient in our Office? ❑ *Yes* ❑ *No*
We expect payment in full at each appointment. For your convenience, we offer the following methods of payment:
• *Cash* • *Personal Check* • *VISA* • *MasterCard* • *Discover* • *Debit Card*

Dental Insurance Information

Name of Insured _____ *Relationship to Patient* _____
Birthdate _____ *SS#/SIN* _____ *Date Employed* _____
Name of Employer _____ *Union or Local #* _____ *Work Phone* _____
Address of Employer _____ *City* _____ *State* _____ *Zip* _____
Insurance Company _____ *Group #* _____ *Policy/ID#* _____
Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____
How much is your Deductible? _____ *How much have you used?* _____ *Max Annual Benefit* _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ *YES* ❑ *NO*