

Welcome To Our Practice

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date _____ Home Phone _____ Cell Phone _____

Name _____ Soc. Sec. # _____
Last First Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birth date _____ Child Single Married Widowed Separated Divorced

Email Address _____

Patient Employed by _____ Occupation _____

Business Phone _____ Ext _____ Whom may we thank for referring you? _____

In case of emergency,
who should be notified? _____ Relationship _____ Phone # _____

Account Info

Person Responsible for account _____ Relationship _____

Address _____ City _____ State _____ Zip _____
(If different from patient)

Home Phone _____ Cell Phone _____ Work Phone _____

Primary Insurance

Subscriber _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec.# _____

Insurance Company _____ Ins Phone # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered on this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No Subscriber _____

Insurance Company _____ Ins. Phone # _____