WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The more you communicate to us, enables us to better care for you.

Today's Date: ________ E-mail Address: ________

Name: ________
Last First Mi Mr Mrs Ms Dr

I prefer to be called: ________ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ____ SS#: ________

Home Address: ________
Apt/Condo #

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: (___)________ Cell: (___)________

Work Phone: (___)________ Ext: ____ Other #: ________

Employer: ________

Employer's Address: ________

____
City State Zip

Length of employment: ________ Occupation: ________

When are the best times to reach you? ________ am ________ pm

Whom may we Thank for referring you? ________

Other family members seen by us: ________

____

Previous / Present Dentist: ________
(Please Circle)
Last Visit Date: ________

Spouse Information:

His / Her Name: ________

Employer: ________

Position: ________ Social Security #: ________

Work Phone: (___)________ Birthdate: ___/___/___

Person Responsible for Account:

Name: ________

Employer: ________ Driver's License #: ________

Work Phone: (___)________ Home Phone: (___)________

Relationship: ________ Social Security #: ________

Billing Address: ________

____

In the event of an emergency, whom should we contact?

His / Her Name: ________ Relation: ________

Work Phone: (___)________ Home Phone: (___)________

PRIMARY INSURANCE

Dental Insurance? ☐ Yes ☐ No

Insurance Co. Name: ________

Insurance Co. Address: ________

Insurance Co. Phone: (___)________

Group Number (Plan, Local or Policy #): ________

Insured's Name: ________ Relation: ________

Insured's Birthdate: ___/___/___ Insured's SS #: ________

Insured's Employer: ________

Employer's Address: ________

____
City State Zip

SECONDARY INSURANCE

Dental Insurance? ☐ Yes ☐ No

Insurance Co. Name: ________

Insurance Co. Address: ________

Insurance Co. Phone: (___)________

Group Number (Plan, Local or Policy #): ________

Insured's Name: ________ Relation: ________

Insured's Birthdate: ___/___/___ Insured's SS #: ________

Insured's Employer: ________

Employer's Address: ________

____
City State Zip

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

____
Signature Date

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

My method of payment will be ________

____
Signature Date

Thank you for filling out this form completely.
If you have any questions at any time, please ask us.

Payment is due in full at time of treatment unless prior arrangements have been approved. A $15.00 billing charge will be applied each month to any account outstanding over 30 days.

Initials ______

© 2009 Informs 1-800-722-4884