WELCOME TO OUR OFFICE

Your Name:____ Today's date:__________
First Middle Last
Home Address:____
City:______________________________ State:_______________ Zip:______________
E-mail address:____
Home Phone:____________Work Phone:_________________ Cell:_________________
Please circle the preferred method of contact:
Home--work-- cell phone-- email or text message
Birthdate:____________________________
Occupation:___________________________ Social Security Number:______________
Employer:____________________________________Phone/Extension:______________

Name of Spouse:___________________________________ Birthdate:_______________
Telephone:______________________________ Cell/or Pager:______________________
Occupation:___________________________ Social Security Number:______________
Employer:______________________________Phone/Extension:____________________

Complete this section ONLY if someone other than the patient is financially responsible.
**Please note that the parent that brings a child for dental care is ultimately the one responsible for the account.
Responsible Party:____________________________ Relationship to Patient:__________
Home Address: ____
City: _______________________________State:_________________Zip:____________
Home Phone: ______________Work Phone:_________________ Cell: ______________
Please circle the preferred method of contact:
Home--work-- cell phone-- email or text message
Birthdate: ____________________________
Occupation: ____________________________Social Security Number: ______________
Employer: _________________________________Phone/Extension: ________________

In the Case of an emergency, contact: ___________________Relationship:___________
Home Phone: __________________Work Phone: __________Cell: ________________
How did you learn about our office?: ____
Referred by:____
(Please see reverse side for insurance information)

DENTAL INSURANCE INFORMATION

Patient's Name: ____

PRIMARY INSURANCE

Name and Address of Company: ____

____

Address City State Zip

Insurance Telephone: ________________________________

Insured's Name: ___________________ ___________________ _______________

Social Security # Date of Birth

Group #: _____________________________ Policy ID#: _____________________

Effective Date of Coverage: ____

Is the patient a Full Time Student: _______What school attending? _______________

SECONDARY INSURANCE

Name and Address of Company: ____

____

Address City State Zip

Insurance Telephone: ________________________________

Insured's Name: ___________________ ___________________ _______________

Social Security # Date of Birth

Group #: _____________________________ Policy ID#: _____________________

Effective Date of Coverage: ____

Our office will file insurance for your procedures, however, copayments are payable on the day services are rendered. Please remember that you are responsible for all fees regardless of insurance coverage.

Signature of patient or legal guardian: _____________________________________

Date: _________________________

I authorize the release of any dental information necessary to process insurance claims, and payment of dental benefits directly to the doctor.

____ Date: __________________

(Signature of insured or authorized person)