Welcome!

Thank you for your confidence in selecting our dental team! We want you to know we take your entire health very seriously and that we will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, and your expectations of our team, please complete this form using ink. If you have questions, or need assistance completing this form please let us know. We will be happy to help.

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ **Date:** _____
Last First MI

□ Male □ Female □ Single □ Married □ Divorced □ Child □ Other: _____

Social Security #: _____ - _____ -_____ **Date of Birth:** _____ / _____ / _____

Home Address: _____ **Home Phone:** (_____) _____
Street Apt # **Work Phone:** (_____) _____ **Ext:** _____
_____
City State Zip **Cell Phone:** (_____) _____

Email Address: _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for this Account: _____
Last First MI

Relationship to Patient: □ Self □ Mother □ Father □ Grandparent □ Sibling □ Legal Guardian
□ Other: _____

Social Security #: _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____

Driver's License # _____

Home Address: _____ **Home Phone:** (_____) _____
Street Apt # **Work Phone:** (_____) _____ **Ext:** _____
_____
City State Zip **Cell Phone:** (_____) _____

Employer: _____ **Military Rank:** _____

INSURANCE COMPANY INFORMATION - PRIMARY COVERAGE

Insured Party: _____ **Date of Birth:** _____ / _____ /_____
Last First MI

Policy Holder Identification #: _____

Relationship to Patient: □ Self □ Spouse □ Mother □ Father □ Legal Guardian

Employer: _____

Insurance Company: _____ **Group #** _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?
□ Another Patient □ Physician □ Dental Specialist □ Practice Promotion □ Yellow Pages
□ Employer □ School □ Newspaper □ Office Sign □ Other: _____

Name of the person or office that referred you to our practice: _____