Welcome

We are pleased to welcome you to our practice.
It is our pleasure to provide you and your family with the best dental care!

PATIENT INFORMATION (Please Print)

Title: ______ **First Name:** ______________________ **MI:** ____ **Last Name:** ______________________

Birth Date: ______________________ **SSN:** ______________________ **Gender:** ☐Male ☐Female

* Patient adult / child

Address: ______________________________________ **Apt./ Suite:** ______________

City: ______________________________ **State:** ________ **Zip Code:** ______________

Phones: **Home:** ______________ **Work:** ______________ **Ext:** ________

Mobile: ______________ **Fax:** ______________ **Email:** ______________________

Employer: ______________________ **Phone:** ______________ **Occupation:** ______________

Whom may we thank for referring you? ______________________________________

*** Most Dental Insurance Companies require Social Security Numbers for each dependent on Insurance Claim**

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: ______ **First Name:** ______________________ **MI:** ____ **Last Name:** ______________________

Relationship to Patient: ☐ self ☐ spouse ☐ child ☐ other - please specify ____________ **Soc Sec.:** ______________________

Address: ______________________________________ **Apt./ Suite:** ______________

City: ______________________________ **State:** ________ **Zip Code:** ______________

Phones: **Home:** ______________ **Work:** ______________ **Ext:** ________

Mobile: ______________ **Fax:** ______________ **Email:** ______________________

Employer: ______________________ **Phone:** ______________ **Occupation:** ______________

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co.: ______________________________

Group #: ____________ **Ins. Phone:** ____________

Employer: ______________________________

Employee (if other than patient)

Name: ______________________________

Birth-date: ____________ **Soc. Sec.:** ____________

Subscriber #: ____________ **Gender:** ☐Male ☐Female

Secondary Insurance

Ins. Co.: ______________________________

Group #: ____________ **Ins. Phone:** ____________

Employer: ______________________________

Employee (if other than patient)

Name: ______________________________

Birth-date: ____________ **Soc. Sec.:** ____________

Subscriber #: ____________ **Gender:** ☐ Male ☐ Female

______________________________________ **Date** ______________________

Signature (parent or guardian if patient is a minor)