Date _____

WELCOME

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

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last First Middle Initial
Address _____
City _____ State_____ Zip_____ Home Phone _____
Cell Phone _____ Email _____
Sex o M o F Age _____ DOB _____ o Single o Married o Widowed o Divorced
Patient Employed by _____ Occupation _____
Business Phone _____ Drivers License # _____
Notify in case of emergency (not living with you) _____
Relationship to patient _____ Phone # _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last First Middle Initial
Relation to Patient _____ Birthdate_____ Soc. Sec. # _____
Address *(if different from patient)* _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____
Insurance Company _____ Group # _____
Subscriber# _____

IF PATIENT IS MINOR OR DEPENDENT:

Father/Mother Last Name: _____ M:_____ First Name:_____
Address: _____ Phone #: _____
DOB: _____ SSN: ____-____-_____ Employer: _____ Work #: _____
( ) Lives with both parents; ( ) Lives with Mother; ( ) Lives with Father; Other: _____
Release of Information:
Please list information of persons, if any, whom we may inform about your general medical condition and your diagnosis (i.e. treatment, payment and dental care operations).
Name: _____ Relationship _____ Phone # _____
Name: _____ Relationship _____ Phone # _____
Name: _____ Relationship _____ Phone # _____