

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS/HIC/Patient ID# _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male Birthdate _____ E-mail _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Do you prefer to receive calls at: Home Work Cell No Preference

Married Widowed Single Minor Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone (_____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (_____) _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (_____) _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Insurance Co. _____

Group # _____ Employer # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

How much is your deductible? _____

How much have you used? _____

Max. annual benefit? _____

