

WELCOME

ABOUT YOU

Today's Date: ___ / ___ / ___ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ___ / ___ / ___ Age: ___ SS#: _____

Mailing Address: _____

Home Phone #: (___) _____ CITY STATE ZIP

Work Phone #: (___) _____ Ext: _____

Cell Phone #: (___) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Occupation: _____ CITY STATE ZIP

Status: Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

Phone #: (___) _____ CITY STATE ZIP

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth ___ / ___ / ___

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

Phone #: (___) _____ CITY STATE ZIP

Insured's SS#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth ___ / ___ / ___

Insured's Employer: _____

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

SS #: _____

Driver's License #: _____

Work Phone #: (___) _____

Payment method: Cash Check _____ / _____

Credit Card - Enter card # above (if accepted)

Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (___) _____

Work Phone #: (___) _____

Cell Phone #: (___) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (___) _____

Please Continue On Back