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 Name *First Name* *Initial*
Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone Email
Sex M ○ F ○ Age ____ Birthdate _____ Single ○ Married ○ Widowed ○ Separated ○ Divorced ○
Patient Employed by _____ Occupation
Business Address _____ Business Phone
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address *(if different from patient)* Home Phone
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber# _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes ○ No ○
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address *(if different from patient)* _____ Soc. Sec.# _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business phone _____
Business Email _____
Insurance Company _____ Phone _____
Contract # _____ Group# _____ Subscriber# _____
Name of other dependents under this plan _____

Send Clear