

WELCOME

1 one

ABOUT YOU

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

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have kids? Yes No How many? _____

2 two

INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

3 three

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: _____

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

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 for by my insurance company (if offered at this office).

Initials

N/A

4 four

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

PLEASE CONTINUE ON BACK