WELCOME

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:_____

Cell Phone #: (_____) _____

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 children? ❑ Yes ❑ No How many? _____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#:_____

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 ID#:_____

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

Insured's Name: _____

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

Insured's Employer: _____

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

four 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