WELCOME

Patient Information

Today's Date: ____/____/____

Patient Name: _____ Preferred Name: _____
First MI Last

Mailing Address: _____
City State Zip

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Cell Phone # : ( ) _____

Which number would you prefer to be confirmed at: Home ___ Work ___ Cell ___

Birthdate: _____/_____/_____ Male ___ Female ___ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Age: _____ SS#: _____ Drivers License #: _____

(If Married) Spouse Name: _____

Are you a Full Time Student? No ___ Yes ___ (If Yes) Where: _____

Place of Employment: _____ Address: _____ Occupation: _____

Emergency Contact Name: _____ Phone# ( ) _____ Relationship: _____

E-mail Address: _____ REFERRED BY: _____

Account Information

Person responsible for account (Fill out **ONLY** if patient is under 18 years of age)

Name: _____ Relationship to Patient: _____

Mailing Address: _____
City State Zip

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Cell Phone # : ( ) _____

Birthdate: _____/_____/_____ Male ___ Female ___

SS#: _____ Drivers License #: _____

Place of Employment: _____ Employment Address: _____

Insurance information

Primary Dental Insurance

Subscriber/Policy Holder Name: _____ Birthdate: ___/___/___

Relationship to Patient: _____

Place of Employment: _____ Employment Address: _____

Name of Insurance: _____ SS# _____ or ID# _____ Group # _____

Insurance Mailing Address: _____ Telephone #: ( )_____