WELCOME

Today's Date _____

To help us better meet your needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Birthdate _____
Address _____ City _____ State _____ Zip _____
If student, name of school _____ Home Phone _____
General Dentist _____ Location _____
Whom may we thank for referring you? _____
Do we treat any other family members? _____
Person to contact in case of Emergency _____ Phone _____

Responsible Party

Name of person Responsible for this Account _____
Relationship to Patient _____ Home Phone _____
Address if Different _____
For your convenience, we offer the following methods of payment. Please check one.
☐ Cash ☐ Personal Check ☐ Visa ☐ Mastercard ☐ I wish to discuss a payment plan

Dental Insurance Information

Name of Insured _____
Relationship to Patient _____ Birthdate _____
Social Security Number _____-_____-_____ Date Employed _____
Name of Employer _____ Phone _____
Employer Address _____
City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Policy / ID # _____ Phone _____
Ins. Co. Address _____
City _____ State _____ Zip _____
How much is your Deductible? $_____ How much has been used? $_____
Maximum Annual Benefit? $_____

Do you have any Additional Dental Insurance? ☐ YES ☐ NO

If Yes, please complete the following

Name of Insured _____
Relationship to Patient _____ Birthdate _____
Social Security Number _____-_____-_____ Date Employed _____
Name of Employer _____ Phone _____
Employer Address _____
City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Policy / ID # _____ Phone _____
Ins. Co. Address _____
City _____ State _____ Zip _____
How much is your Deductible? $_____ How much has been used? $_____
Maximum Annual Benefit? $_____