Welcome!

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as possible. If you have questions we'll be happy to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Today's Date:_____

Home Phone #:_____ Cell Phone #:_____Work Phone #:_____

Mr. / Mrs. / Ms. / Dr. (*circle one*)

Patient Name: _____

Last First Initial Preferred Name

Street Address:_____

City_____ State_____ Zip_____

E-Mail:_____ Sex: ____M_____F Age:_____ Birth date: _____

Single____Married____Widowed____Separated____Divorced____

Occupation:_____ Patient Employer/School:_____

Employer address:_____

Employer Phone No:_____

Spouse Name:_____ Birth date: _____ SS/ID number:_____

Spouse's Employer:_____ Work Phone:_____

Whom may we thank for referring you? _____

Responsible Party Information

Name: Last_____ First_____ Initial ____Marital Status_____

Mailing address:_____ City_____ State_____ Zip _____

Home Phone: _____Work Phone: _____Driver License #:_____

SS/Ins ID #:_____Birth date:_____ Relationship to Patient:_____

Employer Name & Address: _____Years Employed:_____

Dental Insurance Information

Insured's Name: _____ Insured's SS of ID#: _____

Insured's Employer: _____ Group Policy Number:_____

Insurance Co: _____ Ins. Co. Phone Number: _____

Address: _____ City, State, Zip: _____

In case of Emergency, Contact (relative not living with you)

Name: _____ Relationship: _____

Home Phone #: _____ Cell #: _____ Work #: _____