Welcome

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

Patient Information

Name_____ Sex ■M ■F Birthdate_____
First Name Middle Initial Last Name

Address_____ ■Single ■Married ■Widowed ■Separated ■Divorced

City_____State_____Zip_____Soc Sec#___-___-____

Email_____Would you like to receive email correspondences ■ Yes ■No

Home Phone_____Work Phone _____ Cell Phone _____

Would you like to receive text messages regarding your appointments ■ Yes ■No

Whom may we thank for referring you?_____

Notify in case of emergency_____Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient)_____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone_____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone_____

Business Email_____

Insurance Company _____ Phone _____

Contract #_____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient)_____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone_____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone_____

Business Email_____

Insurance Company _____ Phone _____

Contract #_____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

What would you like us to do today?_____

Are you in dental discomfort today?_____

Former Dentist_____Address_____Phone_____

Dentist Email_____Date of last dental care_____Date of last x-rays_____