Welcome to Our Office

Thank you for choosing our dental team to take care of your oral health. Please fill out this form completely, so that we provide you with the best possible care.

Patient Information

Patient Name: _____Preferred Name: _____
Last, First, Middle Initial
Male❑ Female ❑ Married ❑ Single ❑ Child ❑ Other❑
Social Security #: _____Birth date: _____
Phone (home): _____(Work)_____(Other)_____
Email Address:_____
Do you prefer being contacted by phone or email message? _____
Address: _____
Street Apartment #
_____
City State Zip Code
Employer's Name/Address _____
_____ Occupation _____

Insurance Information

Primary
Name of Insured: _____Is insured a patient? Yes ❑ No ❑
Last, First, MI
Insured's Birth Date: _____ID#_____Group_____
Insured's Address:_____
Street City/State Zip Code
Insured Employer's Name: _____
Address: _____
Street City/State Zip Code
Patient's relationship to insured: Self ❑ Spouse ❑ Child ❑ Other❑
Insurance Plan name and address: _____
_____
Phone Number on Card (_____)_____-_____

Responsible Party Information

The following is for: Patient's Spouse ❑ Person Responsible for Payment ❑
Patient Name: _____Preferred Name: _____
Last, First, Middle Initial
Male❑ Female ❑ Married ❑ Single ❑ Child ❑ Other❑
Social Security #: _____Birth date: _____
Phone (home): _____(Work)_____(Other)_____
Address: _____
Street Apartment # City/State Zip Code

Referral Information

Who may we thank for referring you to our practice?
Another patient, friend ❑ Another patient relative ❑ Dental Office ❑ Yellow Pages ❑ Newspaper ❑
Office Sign ❑ Other: _____
Name of person or office referring you to our practice:_____

Please understand that we will work with your primary insurance to the best of our abilities. We cannot file your secondary insurance for you, but we will be happy to give you a receipt for all services rendered.