WELCOME

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)
Patient Name _____ Date _____ SS# _____ - ____ - _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: Female ____ Male ____ Birthdate _____ Driver's License _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Do you prefer to receive calls at: Home _____ Work _____ Cell _____ No Preference _____
Single _____ Married _____Widowed _____ Divorced _____ Separated _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip_____

Spouse or parent's name _____ Employer _____ Work Phone ( ) _____

Whom May We Thank For Referring You To Us? _____
Person to Contact in Case of Emergency _____ Phone ( ) _____
Other Relatives Seen in This Office _____

Responsible Party (if other than patient)

Name of person responsible for this account _____
Relationship to Patient _____ Phone ( ) _____
Birthdate _____ Social Security # _____ - ____ - _____ Driver's License _____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work Phone ( ) _____

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ - ____ - _____ Date employed _____
Name of employer _____ Work Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? NO ___ YES ___ IF YES,PLEASE COMPLETE THE FOLLOWING
Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ - ____ - _____ Date employed_____
Name of employer _____ Work Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for my insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid in whole or in part by my dental care payor. I attest to the accuracy of the information on this page.

PATIENT'S (OR GUARDIAN'S) SIGNATURE _____ DATE _____