Welcome

Date: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Birth Date: _____ SS#: _____

Address: _____ City. State. Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Ext:_____ Cellular: (_____)_____

Drivers License Number: _____

Sex: Male Female Marital Status: Single Married Partnered Divorced/Separated Widowed

E-mail: _____ Would you like to receive correspondence via e-mail? yes no

Employer: _____

How long there? _____ Occupation: _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____ Phone: (_____)_____

Person Responsible for Account: _____

Spouse/Guardian Information:

His / Her Name: _____ SS#: _____

Employer: _____ Work Phone: (_____)_____ Ext:_____

Birth Date: _____ Drivers License Number: _____

Relative or Friend not living with you:

His / Her Name: _____ Relation: _____

Work Phone: (_____)_____ Home Phone: (_____)_____

Insurance Information:

Patient is: Policy Holder Responsible Party Both

Insurance Company Name: _____ Insurance Co. Phone Number: (_____)_____

Group #: _____ Subscriber #: _____ Insured's SS#: _____

Insured's Name: _____ Relation: _____ Insured's Birth date: _____

Insured's Employer: _____

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Direct Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: _____ Date: _____