Welcome to our office...

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The more you communicate to us, the better we are able to care for you.

Today's Date:______________________________

Name:______________________________
Last First MI Mr Mrs Ms Dr

I prefer to be called:________________ ❑ Male ❑ Female

Birthdate:____/____/____ Age:_____ SS#__________________

Home Address:______________________________ Apt. / Condo #

____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Best Phone: (_____)__________ ❑ Home ❑ Work ❑ Cell

Email: ______________________________

Employer:______________________________

Employer's Address______________________________

____
City State Zip

Length of employment:__________ Occupation:__________

When are the best times to reach you? ______am ______ pm

Whom may we thank for referring you?__________________

Other family members seen by us: __________________

____

Previous / Present Dentist:______________________
(Please Circle)

Last Visit Date:______________________

Spouse Information:

His / Her Name:______________________________

Employer:______________________________

Position:______________________ SS#__________________

Work Phone: (_____)__________ Birthdate:_____/_____/_____

Person Responsible for Account:

Name:______________________________

Employer:______________________________

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

Relationship:__________________ SS#__________________

Billing Address:______________________________

In the event of an emergency, whom should we contact?

Name:______________________ Relation__________

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

PRIMARY INSURANCE **Dental Insurance?** ❑ Yes ❑ No

Insurance Co. Name:______________________________

Insurance Co. Address:______________________________

Insurance Co. Phone: (______)______________________

Group Number (Plan, Local or Policy #):__________________

Insured's Name:____________________ Relation__________

Insured's Birthdate:____/____/____ Insured's SS #:__________

Insured's Employer:______________________________

Employer's Address:______________________________

____
City State Zip

SECONDARY INSURANCE **Dental Insurance?** ❑ Yes ❑ No

Insurance Co. Name:______________________________

Insurance Co. Address:______________________________

Insurance Co. Phone: (______)______________________

Group Number (Plan, Local or Policy #):__________________

Insured's Name:____________________ Relation__________

Insured's Birthdate:____/____/____ Insured's SS #:__________

Insured's Employer:______________________________

Employer's Address:______________________________

____
City State Zip

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes.

____
Signature Date

I understand that I am responsible for payment of services rendered.

My method of payment will be: (Please Circle One)

❑ MC ❑ VISA ❑ Discover ❑ Check ❑ Cash

____
Signature Date

Thank you for filling out this form completely. If you have questions at any time, please ask us.

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