

Welcome!

Date: / /

In order to better serve you, we may need the following information (please print)!

Information will be kept strictly confidential.

Patient Contact Information

A. Name

Last: First: Middle:

Address:

City: State: Zip:

Driver's Lic. : SSN: - - D.O.B.: / /

Sex: M / F Marital Status:

Home Phone: () - Work Phone: () - Ext:

Cell Phone: () - Email Address: @

Occupation or School Attending:

Closest Relative (not living with you)

Name: Phone # Relationship:

Emergency Contact (other than Spouse)

Name: Phone # Relationship:

B. Responsible Party Information (check if same as above and move to section C.) or

Relationship to Patient:

Name: DOB: DrvLic#: SSN:

Address:

H() - W() - C() - E @

C. Employer's Name: Employers Phone: () -

Employer's Address:

Spouse's Name: Spouse Work or Cell # () -

Spouse's Employer's Name: Spouse Employers Phone: () -

Spouse's Employer's Address:

D. Payment Information. Payment and/or verification of insurance coverage is required at the time of treatment to arrange for your portion of fees not covered by insurance. We accept the following payment options. Please indicate your choice(s) of payment. We are happy to answer any questions you may have.

Cash Check Credit Card Finance Company Other

If you have dental insurance, please provide the following information:

Table with 2 main columns: Primary Insurance and Secondary Insurance. Rows include Policy Holders Name, Name of Insurance, Address, Phone, Group #, SSN, and DOB.