

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

SS # _____

Date _____

Name _____ Date of Birth _____ Home Phone _____

Address _____
Street or Box _____ City _____ State _____ Zip _____

E Mail Address _____ Fax # _____ Cell Phone # _____

Married (Name of Spouse _____) Minor Single Divorced Widowed Separated

If College Student, Name of College & City _____ Full Time Part Time

Patient's or Parent's Employer _____ Work Phone _____
(If patient is a **child**, please list the father's employer.)

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Responsible Party

Name of Person Responsible for this Account (If Other Than Above) _____ Relationship to Patient _____

Address (If Other than above) _____ Home Phone _____

Insurance Information

Name of Insured _____ Birthdate _____ SS# _____ Relationship to Patient _____

Name of Employer _____ Work Phone _____ Ext. _____

Address of Employer _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____

How much is your Deductible? \$ _____ How Much Have You Used? \$ _____ Max Annual Benefit \$ _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Birthdate _____ SS# _____ Patient _____

Name of Employer _____ Work Phone _____ Ext. _____

Address of Employer _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____

How much is your Deductible? \$ _____ How Much Have You Used? \$ _____ Max Annual Benefit \$ _____

PLEASE ANSWER THIS NEXT QUESTION. THIS IS VERY IMPORTANT TO OUR PRACTICE!

WHERE DID YOU HEAR ABOUT US? PLEASE CIRCLE: NEWSPAPER, YELLOWPAGES, YELLOWBOOK, THE MAGNET, INTERNET,

OR NAME OF PERSON WHO REFERRED YOU: _____

Are you interested in a whitening procedure or changes to your smile? Yes No