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)

Date _____
First Name _____ **Middle Init** ____ **Last Name** _____
Address _____ **City** _____ **State**____ **Zip Code** _____
Birthdate _____ **Social Security #** _____-____-_____
Home Phone (____)_____ **Work Phone**(____)_____ **Cell Phone**(____)_____
Email Address _____

Check Appropriate: **Minor** _____ **Single** _____ **Married** _____
Divorced _____ **Widowed** _____ **Separated** _____

Patient's or Parent's Employer _____
Business Address_____ **City** _____ **State**_____ **Zip Code**_____
Work Phone (____)_____
Spouse or Parent's Name _____
Spouse Employer _____ **Work Phone** (____)_____

If Patient is Student, School/College _____ **City** _____ **State**_____

Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency_____

Whom is Responsible For This Account If Not Yourself _____
Relationship to Patient _____ **Birthdate** _____
Address _____ **City** _____ **State** _____ **Zip Code**_____
Home Phone (____)_____ **Work Phone**(____)_____ **Cell Phone**(____)_____

Insurance Information

Name of Insured _____ **Birthdate** _____ **Relationship to Patient**_____
SS# _____-____-_____ **ID #** _____ **Group #** _____
Date Employed _____ **Name of Employer** _____
Employer Address _____ **City** _____ **State** ___ **Zip Code** _____
Home Phone (____)_____ **Work Phone**(____)_____ **Cell Phone**(____)_____
Insurance Co. _____ **Address** _____
City _____ **State** _____ **Zip Code** _____ **Union of Local #** _____

(continue to next page)

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes_____ No_____
IF YES, COMPLETE THE FOLLOWING:

Secondary Insurance Information

Name of Insured _____ Birthdate _____ Relationship to Patient_____
SS# _____-____-_____ ID # _____ Group # _____
Date Employed _____Name of Employer _____
Employer Address _____City _____State ___ Zip Code _____
Home Phone (____)_____Work Phone(____)_____Cell Phone(____)_____
Insurance Co. _____Address _____
City _____State _____ Zip Code _____ Union of Local # _____

IF YOU HAVE INSURANCE……

We will gladly process your claim but we request that you pay your estimated portion when services are rendered.
Thank You!