WELCOME

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form, if you have questions we would be glad to help you. We are looking forward to working with you in maintaining your dental health.

GENERAL PATIENT INFORMATION

Home Phone ( )_____ Cell Phone ( )_____ Drivers License #_____

Name_____
Last name First name Middle Initial

Address_____ City _____ Zip Code_____

Date of Birth_____ Age_____ Social Security #_____ Sex Male O / Female O

Please Choose One Single O Married O Separated O Divorced O Widowed O Minor O

Employer/School_____ Occupation_____ Employer/School Phone # ( )_____

How did you hear of our office?_____ Previous Dentist_____

Your approximate date of your last cleaning and x-rays?_____ Any Pre-med or allergies?_____

Person to notify in case on an emergency/Relationship_____ Phone # ( )_____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relationship to patient_____ Date of Birth_____ Social Security #_____

Employer_____ Primary Insurance Company_____ Group #_____

Ins. Co. Phone # ( )_____ Ins. Co. Address_____ Contract #_____

ADDITIONAL INSURANCE

Subscriber Name _____
Last Name First Name Middle Initial

Relationship to patient_____ Date of Birth_____ Social Security #_____

Employer_____ Insurance Company_____ Group #_____

Ins. Co. Phone # ( )_____ Ins. Co. Address_____ Contract #_____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. including all collection and billing fees.

SIGNATURE_____ DATE_____