WELCOME TO OUR OFFICE

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: ____________________
Name: ____ Patient's Sex: ☐ F ☐ M
Address: ____
Email: ______________________________ Phone#: ____________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married
Patient or Parent/Guardian's Employer: ____________________ Work Phone#: ______________
Business Address: ____
Spouse or Parent/Guardian's Name: ____
Employer: ______________________________ Work Phone#: ____________________
Whom may we thank for referring you: ____
Person to contact in case of emergency: ____________________ Phone#: ______________

Responsible Party

Name of person Responsible for this Account: ____________________ Phone#: ______________
Relationship to Patient: ____________________ Email: ____________________
Driver's License#: ____________________ Birthdate: ____________________
Employer: ____________________ Work Phone#: ____________________
Is this person currently a patient in our office: ☐ Yes ☐ No

Insurance Information

Name of Insured: ______________________________ Relationship to Patient: ______________
Birthdate: ______________ SS#/SIN: ____________________ Date Employed: ______________
Name of Employer: ______________________________ Work Phone#: ____________________
Address of Employer: ____
Insurance Company: ______________________________ Group#: __________ Policy/ID#: ______________
Insurance Co. Address: ____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No (If Yes, Complete the following)

Name of Insured: ______________________________ Relationship to Patient: ______________
Birthdate: ______________ SS#/SIN: ____________________ Date Employed: ______________
Name of Employer: ______________________________ Work Phone#: ____________________
Address of Employer: ____
Insurance Company: ______________________________ Group#: __________ Policy/ID#: ______________
Insurance Co. Address: ____