Thank you for trusting your dental health & wellbeing with us! We will strive to provide you with the best possible care available! To help us best meet all of your dental healthcare needs, please fill out this form. If you have any questions or need assistance, please ask us- We are happy to help!

PATIENT INFORMATION (CONFIDENTIAL)

DATE: ______________

NAME: ______________________________ SS#: ______________
BIRTHDATE: ______________
ADDRESS: ______________________________
CITY/STATE: ______________________________ ZIP: ______________
HOME PHONE: ______________ CELL PHONE: ______________
(**Please CIRCLE your PREFFERED telephone number- that you would like us to reach you at)

EMAIL: ______________________________
OCCUPATION: ______________ EMPLOYER: ______________
PERSON to CONTACT IN CASE OF EMERGENCY? ______________
RELATIONSHIP: ______________ PHONE #: ______________

CHECK APPROPRIATE BOX:

□ Married □ Single □ Seperated/Divorced □Widowed
□ Minor (Please list guardian/responsible party for consents/tx/etc) ______________
□ College Student (Where?) ______________

HOW DID YOU HEAR ABOUT US? IS THERE SOMEONE WE MAY THANK FOR REFFERING YOU?

□ Referral (Name of referral): ______________ □ Referral from Insurance Co./website
□ Advertisement- (Radio/bulletin listing, etc) □ PostCard/Mailings □ Google/Online search
□ Website □ FaceBook □ Saw our office when happened to be in the area (driving/walking/etc)

PARTY FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (if different than patient)

NAME: ______________ SS#: ______________ BIRTHDATE: ______________
ADDRESS: ______________________________
CITY/STATE: ______________________________ ZIP: ______________
EMAIL: ______________________________
HOME PHONE: ______________ CELL PHONE: ______________
RELATIONSHIP TO PATIENT: ______________________________

PRIMARY DENTAL INSURANCE (IF ANY)

SUBSCRIBER NAME: ______________ RELATIONSHIP TO PATIENT: ______________
DOB: ______________ SS#: ______________
ADDRESS: ______________ CITY/STATE: ______________ ZIP: ______________
EMPLOYER: ______________
INSURANCE CO: ______________ GROUP #: ______________ CONTRACT #: ______________

SECONDARY DENTAL INSURANCE (IF ANY)

SUBSCRIBER NAME: ______________ RELATIONSHIP TO PATIENT: ______________
DOB: ______________ SS#: ______________
ADDRESS: ______________ CITY/STATE: ______________ ZIP: ______________
EMPLOYER: ______________
INSURANCE CO: ______________ GROUP #: ______________ CONTRACT #: ______________