WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The more you communicate to us, enables us to better care for you.

Today's Date: _____ E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: (____)_____ Cell: (____)_____

Work Phone: (____)_____ Ext: _____ Other #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Length of employment: _____ Occupation: _____

When are the best times to reach you? _____ am _____ pm

Whom may we Thank for referring you? _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Spouse Information:

His / Her Name: _____

Employer: _____

Position: _____ Social Security #: _____

Work Phone: (____)_____ Birthdate: ____/____/____

Person Responsible for Account:

Name: _____

Employer: _____ Driver's License #: _____

Work Phone: (____)_____ Home Phone: (____)_____

Relationship: _____ Social Security #: _____

Billing Address: _____

_____

In the event of an emergency, whom should we contact?

His / Her Name: _____ Relation: _____

Work Phone: (____)_____ Home Phone: (____)_____

PRIMARY INSURANCE

Dental Insurance? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____)_____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

SECONDARY INSURANCE

Dental Insurance? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____)_____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

_____
Signature Date

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

My method of payment will be _____

_____
Signature Date

Thank you for filling out this form completely.
If you have any questions at any time, please ask us. Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

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