

Personal Contact Information:

Today's Date: _____

Name: (First) _____ (Middle Initial) _____ (Last) _____

Preferred Name: _____ () Male () Female

Address: _____ () Home () Other

Birth date: ____/____/____ Age: _____ SS#: _____

Please check one: () Single () Married () Divorced () Widowed () Separated () Child

Your Phone Numbers:

(Home) _____ () Best # to call () Leave message here () Do not call

(Work) _____ () Best # to call () Leave message here () Do not call

(Cell) _____ () Best # to call () Leave message here () Do not call

Email Address: _____ @ _____

() I would like to receive confirmation & other correspondence by email

Spouse Information: (Name) _____ () Male () Female

Contact them @: _____ () Home # () Cell # () Work #

Additional contact information: _____

() We may share your dental care & appointments with this person.

() Do not share any information with this person

() Share the following information: _____

Other people who are authorized to discuss your dental care and appointments:

(Name): _____ (Contact #) _____ (Relationship) _____

***In Case of Emergency, we should contact: (Name): _____

(Contact #'s) _____ (Relationship) _____

How did you hear about our office? () Another patient: _____

() Internet () Other: _____

Financial Information:

Your Employer: _____

Employer address/contact information: _____

Do you have dental insurance coverage? () YES () NO

Primary Dental Insurance Coverage:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Plan #: _____

Member ID #: () SS# () Other: _____

Is your dental insurance coverage provided by you or another person? () Self () Other

If other, please provide the following:

Insured Person's Name: _____ Relationship: _____

Insured's Birth date: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Person responsible for account: () You () Other: _____ (Relation) _____

If other, please provide the responsible party's Address:

Contact #'s: (Home) _____ (Cell) _____ (Work) _____

Do you have secondary insurance coverage? () YES () NO

*Please see front desk about filing your secondary insurance