Getting to Know You

We are pleased to welcome you to our dental home. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to helping you achieve dental health.

Today's Date _____

Patient Information

Patient Name: _____ I prefer to be called: _____
Address: _____ City:_____ State:_____ ZIP:_____
Home phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____
Birth date: _____/_____/_____ Age: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Social Security #: _____ Student? ☐ Yes ☐ No School: _____
Hobbies and Interests: _____
Other family members seen by us: _____
Person to contact for an emergency: _____ Phone # _____

Contact

Because we know your life is busy, we use an Electronic Appointment Reminder and Messaging System.
Please √ all that you prefer as our best way to contact you.

☐ Email ☐ Text Message ☐ Personal Phone Call to: ☐ Home ☐ Work ☐ Cell ☐ I don't need a reminder

Person Responsible for This Account

Person's Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Home phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____
Birth date: _____/_____/_____ Age: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Social Security #: _____ Relation to Patient: _____

Your Spouse

Person's Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Home phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____
Birth date: _____/_____/_____ Age: _____ ☐ Male ☐ Female
Social Security #: _____

Employer Information

Your Employer: _____ Spouse's Employer: _____
Address: _____ Address: _____
Phone #: _____ Extension: _____ Phone #: _____ Extension: _____

How Did You Hear About Us?

√ Check all that apply:

☐ Family/friend _____ ☐ Co-worker _____ Other Doctor _____

☐ 1-800 Dentist ☐ Radio ☐ TV ☐ Yellow Pages ☐ Drove by ☐ Internet ☐ Other _____
If you found us on the internet, what search words did you use?_____

Dental Insurance Information

Primary Dental Coverage

Who is the insured person? _____ Insured's Date of Birth: ____/____/____

Insured's Employer _____ Insurance Company Name: _____

Insured's Soc. Sec. #: _____ Insured's I.D. #: _____ Group # _____

Secondary Dental Coverage

Who is the insured person? _____ Insured's Date of Birth:____/____/____

Insured's Employer: _____ Insurance Company Name: _____

Insured's Soc. Sec. #: _____ Insured's I.D. #: _____ Group #: _____

Consent for Treatment

1. I hereby authorize doctor or designated team member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated team member's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment , and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6. I understand that for any returned check, a $25 charge will be added to my account.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____