WELCOME TO OUR OFFICE

Tell Us About Yourself

Date: _____ **Email**:_____
Name: _____**Preferred Name**:_____
Last First MI Mr. Mrs. Ms. Dr.
Birth Date:___/___/____ **Age**:_____ **Social Security Number**:____-__-___ **Marital Status**: S M D W
Home Address:_____
Street City State
Zip
Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Work Phone: (____)___-____ Ext:___
DL#:_____
When & where are the best times to reach you?_____
Other family members seen by us:_____
Whom may we thank for referring you to our office?_____

Employer:_____ **Occupation**:_____
Address:_____
Street/PO Box City State
Zip

Neighbor or Relative Not Living With You

His/Her Name:_____ Relation:_____ Phone: (___)___-_____

Spouse Information

His/Her Name:_____ Birth Date:___/___/___ Social Security:__-__-___
Employer:_____ Work Phone: (___)___-____ Ext:_____ DL#:_____

Person Responsible for Account if Other Than Yourself

Name:_____ Relation:_____ Phone: (___)____-_____
Birth Date: ____/___/_____ Social Security Number:____-___-____
Employer:_____ Work Phone: (___)___-____ Ext.:_____ DL#:_____
Billing Address:_____
Street City State Zip

Insurance Information

Primary Insurance: Dental Y/N Medical Y/N
Insurance Name:_____ Phone: (____)____-_____ Group #:(Plan/Policy)_____
Insurance Address:_____
Street/ PO Box City State
Zip
Insured's Name:_____ Social Security Number:____-___-_____ BirthDate:___/__/___ Relation:_____
Insured's Employer:_____ Address:_____
Street/PO Box City State
Zip

Secondary Insurance: Dental Y/N Medical Y/N
Insurance Name:_____ Phone: (____)____-_____ Group #:(Plan/Policy)_____
Insurance Address:_____
Street/ PO Box City State
Zip
Insured's Name:_____ Social Security Number:____-___-_____ BirthDate:___/__/___ Relation:_____
Insured's Employer:_____ Address:_____
Street/PO Box City State
Zip

Authorization & Release

I authorize the dentist(s) to release information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other healthcare practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

Signature of Patient, Guardian, or Personal Representative Date

Please print name of Patient, Guardian, or Personal Representative Date