WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION FORM

NAME (first middle last):_____ SEX: M_____ F_____

HOME ADDRESS:_____ZIP CODE_____

EMAIL _____ SS#_____-_____-_____ DOB:_____

HOME PHONE:_____ WORK PHONE_____ CELL PHONE_____

EMPLOYER_____FULLTIME STUDENT, NAME OF SCHOOL _____

PERSON TO CONTACT IN CASE OF EMERGENCY_____PHONE #_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

HOW DID YOU HEAR ABOUT US: YELLOW PAGES____ INTERNET___ INSURANCE CO_____ NEWSPAPER AD ____ OTHER_____

RESPONSIBLE PARTY (If same as above write self)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____HOME PHONE_____

EMPLOYER_____WORK PHONE_____SS#_____

DRIVER'S LICENSE#_____ DOB_____ CELL PHONE_____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:_____RELATIONSHIP TO PATIENT:_____

SUBSCRIBER ADDRESS:_____

EMPLOYER_____MEMBER ID#_____SS#_____

DOB:_____/_____/_____ INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS_____

PLAN NAME: _____GROUP #:_____UNION OR LOCAL#_____

ANNUAL MAXIMUM_____INDIV. YEARLY DEDUCT:_____FAMILY DEDUCTIBLE_____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:_____RELATIONSHIP TO PATIENT:_____

SUBCRIBER ADDRESS:_____

SS#_____PATIENT ID#_____EMPLOYER _____

DOB:_____/_____/_____INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS_____

PLAN NAME: _____GROUP #:_____UNION OR LOCAL#_____

ANNUAL MAXIMUM_____INDIV. YEARLY DEDUCT:_____FAMILY DEDUCTIBLE_____

X _____

SIGATURE OF PATIENT OR PARENT IF MINOR