Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ ODL# _____
Address _____ City _____State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email address _____ SSN/SIN _____
Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Person to contact in case of emergency _____
Whom may we thank for referring you? _____

Responsible Party

Check if same as above ☐ Relationship
Name of person responsible for this account _____to patient _____
Address _____
Birthdate _____ ODL# _____ SSN/SIN _____
Home Phone _____ Work Phone _____ Cell Phone _____
Is the Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Relationship
Name of Insured _____ to patient _____
Birthdate _____ SSN/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____
Insurance Company _____ Group # _____ ID# _____
Ins. Co. Address _____
How much is your Deductable? _____How much have you used? _____ Max. Annual Benefits _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Relationship
Name of Insured _____ to patient _____
Birthdate _____ SSN/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____
Insurance Company _____ Group # _____ ID# _____
Ins. Co. Address _____
How much is your Deductable? _____How much have you used? _____ Max. Annual Benefits _____