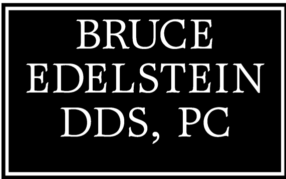

Welcome To Our Office

ABOUT YOU

Today's Date:__________________

Name: ____

I prefer to be called:___________________________________

Home Address: ______________________________________

____

Home Phone: (____)____________________________________

Work Phone: (____)_________________________Ext:__________

Email Address: ______________________________________

Social Security Number: _______________________________

Birthdate: ____________________________________

Single Married Divorced Widowed Separated

Male Female

Whom may we thank for referring you? _____________________

Previous/Present Dentist: ______________________________

Last Visit Date: ______________________________________

Other family members seen by us: _______________________

Employer: ____

Occupation: ____

Employer's Address: ____________________________________

____

SPOUSE OR SIGNIFICANT OTHER INFORMATION (if applicable)

Spouse's name: _____________________________________

Spouse's Employer: ___________________________________

Work Phone: (____)_________________________Ext:__________

Spouse's Social Security Number: _________________________

Spouse's Birthdate: ______________________________

ACCOUNT INFORMATION

Person Responsible for Account: __________________________

Relation: __________________S.S.# _________________________

Home Phone: (____)____________________________________

Work Phone: (____)_________________________Ext:__________

Billing Address: ______________________________________

____

Employer: ____

Fill in below if you need our assistance in maximizing your insurance benefits.

PRIMARY DENTAL INSURANCE (if applicable)

Insurance Company Name: ______________________________

Phone Number: (____)__________________________________

Insurance Co. Address: ________________________________

____

Group Number: _______________________________________

Insured's Name: ______________________________________

Relation: ____

Insured's Birthdate: ___________________________________

Insured's Insurance ID Number:__________________________

Insured's Social Security Number: _______________________

Insured's Employer: ____________________________________

SECONDARY DENTAL INSURANCE (if applicable)

Insurance Company Name: ______________________________

Phone Number:_______________________________________

Insurance Co. Address_________________________________

Group Number: _______________________________________

Insured's Name: ______________________________________

Relation: ____

Insured's Birthdate: ___________________________________

Insured's Social Security Number: _______________________

Insured's Employer: ____________________________________

MEDICAL INSURANCE (if applicable)

Insurance Company Name: ______________________________

Phone Number:_______________________________________

Insurance Co. Address_________________________________

Group Number: _______________________________________

Insured's Name: ______________________________________

Relation: ____

Insured's Birthdate: ___________________________________

Insured's Social Security Number: _______________________

Insured's Employer: ____________________________________