WELCOME

ABOUT YOU

Today's Date: ____/____/____

Patient Name: ____________________

What you Prefer to Be Called:______________ M/F

Birth date:____/____/____Age: ___ SS#:____________

Mailing Address: ____________________

____

Home Phone: (_____)____________________

Work Phone: (_____)____________________

Cell Phone: (_____)____________________

E-mail Address: ____________________

Previous Dentist: ____________________

Referred By: ____________________

Status: Single __ Married __ Divorced __ Widowed__

ACCOUNT INFO

Person Responsible for account

Name: ____________________

Relation: ____________________

Billing Address: ____________________

____

SS#: ____________________

Work Phone#: ____________________

_____ **Initials** I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

_____ **Initials** I have read & agree with the financial policy.

INSURANCE

Primary Dental Insurance

Employer: ____________________

Address: ____________________

____

Phone #: (___) ____________________

Insurance Company ____________________

Insured's ID: ____________________

Group # (Plan, Local, or Policy #): ____________________

Insured's Name: ____________________

Relation: __________ Date of Birth: ___/___/___

Secondary Insurance

Employer: ____________________

Address: ____________________

____

Phone#: (___) ____________________

Insurance Company ____________________

Insured's ID#: ____________________

Group # (Plan, Local, or Policy #): ____________________

Insured's Name: ____________________

Relation: ______________ Date Of Birth: ___/___/___

EMERGENCY INFO

Emergency Contact: ____________________

Relation: ____________________

Home Phone#: ____________________

Work Phone#: ____________________

Cell Phone #: ____________________

Medical Doctor: ______________ Phone:__________