- WELCOME -

Thank you for selecting our dental healthcare team – we are pleased to welcome you to our practice! To help us better serve you and meet your dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us – we are happy to help!

PERSONAL INFORMATION

Date ______________________________

Name ______________________ Date of Birth ______________

Preferred Name ______________________ Soc. Sec.# ______________

Sex: F ☐ M ☐ Minor ☐ Single ☐ Married ☐ Drivers License # ______________

Address ______________________________

City ______________________ State/Zip ______________

Employer ______________________ Occupation ______________

Business Address ______________________________

Whom may we thank for referring you? ______________________________

SPOUSE OR RESPONSIBLE PARTY

(Person responsible for account)

Name ______________________ Date of Birth ______________

Relationship to patient ______________________________

Soc. Sec.# ______________________ Drivers License # ______________

Address ______________________________

City ______________________ State/Zip ______________

Employer ______________________ Occupation ______________

Work Phone ______________________ Ext.# ______________

Home Phone ______________________ Cell Phone ______________

E-mail ______________________________

CONTACT / TELEPHONE

Home Phone ______________ Work Phone + extension ______________

Cell Phone ______________________ Pager ______________

E-mail ______________________________

What is the best way to contact you in person? Home ☐ Work ☐ Cell ☐

Do you prefer to receive correspondence by e-mail? Yes ☐ No ☐

When is the best time to reach you? Days ______________ Time ______________

In the event of an emergency, who should we contact?

Name ______________________ Relationship ______________

Work Phone ______________________ Home Phone ______________

CONTINUED ON BACK

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured ____________________
Relationship to Patient ____________________
Insured's Birthdate ____________________
Subscriber ID# ____________________
Employer ____________________
Insurance Company ____________________
Group# ____________________
Ins. Co. Address ____________________
Ins. Co. Phone ____________________

SECONDARY INSURANCE

Name of Insured ____________________
Relationship to Patient ____________________
Insured's Birthdate ____________________
Subscriber ID# ____________________
Employer ____________________
Insurance Company ____________________
Group# ____________________
Ins. Co. Address ____________________
Ins. Co. Phone ____________________

AUTHORIZATION AND RELEASE

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay directly to the dentist insurance benefits for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature ____ Date _______________
OF PATIENT OR PARENT/GUARDIAN IF MINOR

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.