WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Email Address: _____

Home Address: _____

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Partnered ❑ Divorced/Separated ❑ Widowed

Cell #: (____)_____ Home / Other #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
Please Circle

Person Responsible for Account: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ Driver's License #: _____

Relative or Friend not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Home #: (____)_____

3 Insurance Coverage

Primary Insurance

Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Secondary Insurance

Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Medical Insurance

Medical Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Payment is due in full at the time of treatment

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

CONTINUED ON BACK

Let your smile change the world
Don't let the world change your smile