We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can.
If you have questions, we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name_____ Soc. Sec. # _____
First Name *Last Name*
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Work Phone _____ E-Mail _____
Sex: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Age _____ Birth date _____ Drivers License # _____
Notify in case of emergency _____ Relation _____
Home Phone _____ Cell _____ Work _____
Whom may we thank for referring you? _____

PRIMARY INSURANCE

Person Responsible for Account _____
First Name *Last Name*
Relation to Patient _____ Birth date _____ Soc. Sec. # _____
Address *(if different from patient)* _____ Home Phone _____
City _____ State _____ Zip Code _____
Cell Phone _____ E-Mail _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business E-Mail _____
Insurance Company _____ Phone _____
Insurance E-Mail _____
Contract # _____ Group # _____ Subscriber # _____