WELCOME

The following information is requested in order to establish you as a patient of record. All information will be held in strict confidence.

Date: _____ Referred By: _____

PATIENT INFORMATION:

Email: _____

Name Mr. Mrs. Miss Ms. _____
(Last) (First) (M.I.)

Home Address: _____ City: _____ St: _____ Zip: _____

Home Phone: ( ) _____ Date of Birth: _____

Driver's Lic. # : _____ State: _____ SSN# _____

Cell Phone: _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone: _____

Address: _____

_____

FINANCIAL INFORMATION:

Who will be financially responsible for this account?

Name Mr. Mrs. Miss Ms. _____
(Last) (First) (M.I.)

Home Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (___) _____ Relationship to Patient: _____

Driver's Lic. # : _____ State: _____ SSN# _____

Date of Birth: _____

RESPONSIBLE PARTY

Employer: _____

How Long: _____

Occupation: _____

Position: _____

Business Address: _____

Business Phone: (___) _____

SPOUSE

Name: _____

Employer: _____

How Long: _____ Occupation: _____

Position: _____

Business Address: _____

Business Phone: (___) _____

DENTAL INSURANCE INFORMATION:

Name of Insurance Company: _____

Employer's Name: _____

Policy Holder's Name _____

Social Security Number _____

Phone Number to Verify Coverage: _____

Insurance Co. Address: _____

City, State, Zip: _____

_____

Please list any other members covered under this dental insurance plan:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____