Thank you for choosing our practice for your dental care needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

Patient Information

Name____ Address____

City ____________________ State ______ Zip _______ Home Phone#________________ Cell Phone#________________

Patient's or Parent's Employer____ Work Phone# ________________________

Business Address ____ City __________________ State_____ Zip ___________

Sex M F Marital Status _______________________ Birth Date _____/_____/_____ Present Age _________________

Social Security # _____________________ E-Mail Address ____

Spouse or Parent's Name __________________________ Employer _________________________ Work # ____________

Business Address ____ City __________________ State _____ Zip ___________

Whom May We Thank for Referring You? ____

Person to Contact in Case of Emergency ___________________________________ Phone # _________________________

Responsible Party

Name of Person Responsible For Account ____

Address ____ City __________________ State _____ Zip ___________

Relation to Patient _______________________ Home Phone # _____________________ Cell Phone # ________________

Employer _____________________________ City _________________________ State ________ Zip _________________

Social Security # _______________________________ Work Phone # ____

Primary Insurance Information

Name of Policy Holder ____ Relation to Patient ______________________

Policy Holder's Birth Date _____/_____/_____ Name of Policy Holder's Employer ________________________________

Address of Employer ____________________________________ City ___________________ State _____ Zip ___________

Insurance Company Name _____________________________ Policy ID # __________________ Group # ______________

Insurance Company Address ______________________________ City ___________________ State _____ Zip ___________

Insurance Company Phone # _______________________________ Policy Holder's Social Security # __________________

Secondary Insurance Information

Name of Policy Holder ____ Relation to Patient ______________________

Policy Holder's Birth Date _____/_____/_____ Name of Policy Holder's Employer ________________________________

Address of Employer ____________________________________ City ___________________ State _____ Zip ___________

Insurance Company Name _____________________________ Policy ID # __________________ Group # ______________

Insurance Company Address ______________________________ City ___________________ State _____ Zip ___________

Insurance Company Phone # _______________________________