WELCOME TO OUR PRACTICE

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DATE:

Thank you for choosing our office.

In order to serve you properly we will need the following information. (Please Print) All information will be strictly confidential.

Patient's Name: | Date of Birth: | Marital Status:
| | Single □ Married □
| | Widowed □ Divorced □

E-mail address:

Resident Address: City: State: Zip: |Home Phone:
|Cell Phone
|Work Phone: ext.:

If child, Parent/Guardian's name:

Name of Employer: Address:

Social Security Number: Driver's License: Occupation:

Do you have Dental Insurance? YES□ NO□ | If no, how do you intend to pay? □ Check □ Cash □ Credit Card | Insurance Co. Name & Address

Subscriber Name: Member ID Number: Group Number: Is it through your employer? Yes□ No□

Name of Spouse: | Spouse's Date of Birth: | Spouse's Social Security Number

Do you have secondary Insurance? □ YES □ NO | Name & address of spouse's employer: Business Phone:

Secondary Insurance Name & Address: Member ID Number: Group Number:

Medicaid ID Number: Medicare ID Number:

Person financially responsible for this account: Address: Relationship to Patient

Nearest friend or relative not residing with you: Relationship to Patient Phone:

Whom may we thank for referring you? Address

What is your chief complaint?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian Signature _____ Date _____