Welcome

Please fill out this form completely.
The better we communicate, the better we can care for you.

Today's Date:_____/_____/200___

Patient's Legal Name:_______________________________

Prefer to be called:___________________ ☐ Male ☐ Female

Birthdate:_____/_____/_____ Age: _______

SS#:______ - _____ - _______

Home Address:____

____

Hm #: (____) ______-_______ Cell #: (____) ______-_______

Previous / Present Dentist:___________________________

Last Visit Date:______________________________________

Parent Information (for anyone under 18)

Mother's Name:___________________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address:____

____

Hm #: (____) ______-_______ Cell #: (____) ______-_______

E-mail ____

Birthdate:_____/_____/_____ SS#:______ - _____ - _______

Employer: _________________ Job Title:________________

Employer's Address:___________________________________

____

Wk #: (____) ______-_______

Father's Name:____________________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address:____

____

Hm #: (____) ______-_______ Cell #: (____) ______-_______

E-mail ____

Birthdate:_____/_____/_____ SS#:______ - _____ - _______

Employer: _________________ Job Title:________________

Employer's Address:___________________________________

____

Wk #: (____) ______-_______

Guardian's name: _________________________________

Relationship if other than parent:_______________________

Other family members seen by us:

________________________ ________________________

________________________ ________________________

________________________ ________________________

Person Responsible for Account

Name:___________________________Relation:_____________

Home Address:____

____

Employer: ____

Hm #: (____) ______-_______ Cell #: (____) ______-_______

Wk #: (____) ______-_______ SS#:______ - _____ - _______

Contact in Case of Emergency

Name:________________________Relation:________________

Home # (_____) _______-__________

Cell # (______) _______-__________

Work # (______) _______-__________ ext_________

Primary Dental Insurance

Insurance Co. Name:__________________________________

Insurance Co. Address:________________________________

Insurance Co. Phone #: (____) ______-_______

ID #:________________________ Group #: _____________

Insured's Name:________________ Relation:______________

Insured's Birthdate: ____/____/____ SS#:_____ - ____- ______

Insured's Employer:___________________________________

Secondary Dental Insurance

Insurance Co. Name:__________________________________

Insurance Co. Address:________________________________

Insurance Co. Phone #: (____) ______-_______

ID #:________________________ Group #: _____________

Insured's Name:________________ Relation:______________

Insured's Birthdate: ____/____/____ SS#:_____ - ____- ______

Insured's Employer:___________________________________

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.**

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductibles at the time the service is rendered.

This office reserves the right to verify the credit status of patients and/or parents of minor patients.

Signature:___________________________ Date:______________

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.