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Welcome to our office!

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Last Name: _____ First Name: _____ Middle Initial _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address (if different): _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Driver's License #: _____ State: _____ Social Security #: _____

Spouse/Parent Name: _____ Phone: _____

Emergency Contact (other than spouse): _____ Phone: _____

Name of Employer: _____ Business Phone: _____ Ext. _____

Employer Address: _____

Primary Insurance

Primary Dental Insurance: _____

Company Address: _____ Phone: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Subscriber's Social Security #: _____ Group #: _____

Secondary Insurance

Secondary Dental Insurance: _____

Company Address: _____ Phone: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Subscriber's Social Security #: _____ Group #: _____

Who Can We Thank?

Referred to us by: ☐ Friend: _____ ☐ Other (please specify): _____

I consent for digital images (photographs) of my tissues to be used for educational purposes by this office.
I understand that all charges incurred are my responsibility regardless of insurance reimbursement.

Patient/Parent Signature: _____ Date: _____/_____/_____