Welcome

Thank you for selecting our dental healthcare team to serve your dental needs. We shall endeaveor to provide you with quality dental healthcare. Our office is committed to meeting or exceeding the standards of infection control. Please fill out this form completely. If you have any questions now or at any time during your treatment, please do not hesitate to ask. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI Mr. / Mrs. / Ms / Dr

I prefer to be called _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS# _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

E-mail Address: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Seperated

Hm #: _____ Pager / Other # _____

Wk #: _____ Ext: _____ DL # _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we **Thank** for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle One)

Last Visit Date: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: _____ Ext: _____ Hm#: _____

Birthdate: ___ / ___ / ___ DL #: _____

Person Responsible for Account: _____

Wk #: _____ Ext: _____ Hm#: _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Insured's Birthdate: ___/___/___ SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Insured's Birthdate: ___/___/___ SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her name: _____ Relation: _____

Wk #: _____ Hm #: _____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____