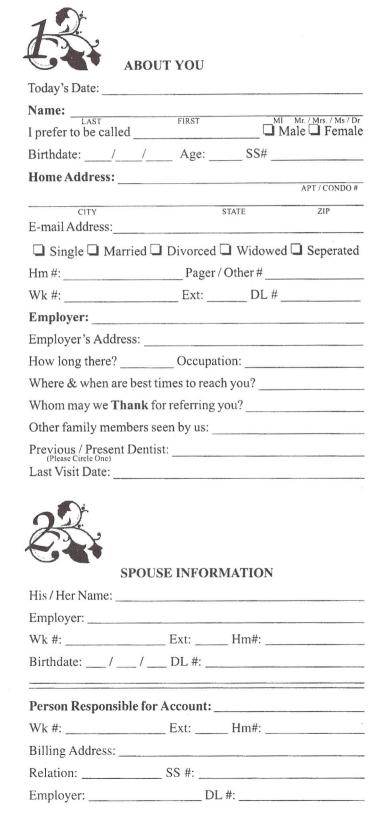


Thank you for selecting our dental healthcare team to serve your dental needs. We shall endeaveor to provide you with quality dental healthcare. Our office is committed to meeting or exceeding the standards of infection control. Please fill out this form completely. If you have any questions now or at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





Primary Dental Insurance

msurance 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 #:
A.
MEDICAL HISTORY
Do you have a personal physician? Yes No
Physician's Name

Phone #: _____ Date of last visit: _____