Welcome

I. About You

Today's Date: _____ File #: _____

Patient Name: _____
Last First MI

What You Prefer To Be Called: _____ ◯ Male ◯ Female

Birth Date: _____ Age: _____ SS #: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #S: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have kids? ◯ Yes ◯ No How many? _____

II. Insurance Info:

Primary Dental Insurance:

Co. Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Insured's SS#: _____

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

Insured's Name: _____

Relation: _____ Date of birth: _____

Insured's Employer: _____

Secondary Dental Insurance: _____

Co. Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Insured's SS#: _____

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

Insured's Name: _____

Relation: _____ Date of birth: _____

Insured's Employer: _____

III. Account Info

Person Ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

SS#: _____

Driver License #: _____

Work Phone #: _____

Payment Method: ☐ Cash ☐ Check

_____ _____

☐ Credit Card (If accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).

IV. In Event of Emergency

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____