Welcome

Patient Information (confidential)

NAME______________________________DATE__________
ADDRESS____
CITY______________STATE________Zip Code__________
HOME PHONE# (______)_____________________________
WORK PHONE# (______)_____________________Ext.____
SOC. SEC.#_____-_____-_____BIRTHDATE_____/_____/_____

Check Appropriate Box ☐ Child ☐ Widowed ☐ Single ☐ Married ☐ Divorced

If Patient/Self is a college student, School name__________________
☐ Full time student ☐ Part time student ☐ Covered under family Dental Plan

Whom may we thank for referring you?

Responsible Party ☐ check this box if same as above

NAME____
ADDRESS____
CITY______________STATE________Zip Code___________
HOME PHONE# (______)______________________________
WORK PHONE# (______)_____________________Ext._____
SOC. SEC.#_____-_____-_____Birthday_____/_____/_____
Employers Name____________________________________

DENTAL INSURANCE (Primary)

Name of Insured____________________Relationship to Patient__________
SOC. SEC.#_____-_____-_____BIRTHDATE_____/_____/_____
Employers Name & Address__________________________________
____Phone#__________
Insurance Company Name____________________Phone#__________
Billing Address____
Group #____________________Union /Local#__________________

DENTAL INSURANCE (Secondary)

Name of Insured____________________Relationship to Patient__________
SOC. SEC.#_____-_____-_____BIRTHDATE_____/_____/_____
Employers Name & Address__________________________________
____Phone#__________
Insurance Company Name____________________Phone#__________
Billing Address____
Group #____________________Union /Local#__________________

OVER