

Welcome To Our Practice

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please print this form, fill it out and bring with you to your appointment. If you have any questions, please call us; we will be happy to help.

Patient Information

Name:	Date:
DOB: Male___ Female___	SSN:
Parent/Guardian(if patient is under 18):	
Address:	
City:	State: Zip Code:
Referred By:	
Home Phone: ()	Cell Phone: ()
Work Phone: ()	Ext: Email:
How would you like to be contacted for your appointment confirmation? ___Home ___Cell ___Work	
Emergency Contact Information:	
Name:	Relationship:
Home Phone: ()	Cell Phone: ()
Work Phone: ()	Ext:

Insurance Information:

Primary Insurance Company:	Plan Type:
Insured's Name:	Relationship to Patient:
Insured's DOB:	Insured's SSN:
Insured's ID #:	Group #
Employer:	
Employer's Address:	
City:	State: Zip Code:
Secondary Insurance Company:	Plan Type:
Insured's Name:	Relationship to Patient:
Insured's DOB:	Insured's SSN:
Insured's ID #:	Group #
Employer:	
Employer's Address:	
City:	

