WELCOME

ABOUT YOU

Today's Date:_____

Name:_____
Last **First**

I prefer to be called:_____ ❍ M ❍ F

Birthdate:_____ Age:___ **SS#:**_____

Home Address:_____

_____
City State Zip

❍Single ❍Married ❍Divorced ❍Widower

Hm #:_____ Other #:_____

Wk #:_____ Ext:_____

Employer:_____

Employer's Address:_____

Occupation:_____

Best times to reach you?_____

Whom may we thank for referring you?_____

Previous/ Present Dentist:_____

SPOUSE/Parent INFORMATION

His/ Her Name:_____

Employer:_____

Wk: #:_____ SS#:_____

Birthdate:_____

……

Person Responsible for Account:_____

Address (if different):_____

_____

Relationship:_____

DENTAL INSURANCE

Primary Dental Insurance

Ins. Co. Name:_____

Ins. Co. Address:_____

Ins. Co. Phone #:_____

Group #:_____

Subscriber's Name:_____

Subscriber's Birthdate:_____ SS#:_____

Subscriber's Employer:_____

Subscriber's Address:_____

……

Secondary Dental Insurance

Ins. Co. Name:_____

Ins. Co. Address:_____

Ins. Co. Phone #:_____

Group #:_____

Subscriber's Name:_____

Subscriber's Birthdate:_____ SS#:_____

Subscriber's Employer:_____

Subscriber's Address:_____

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

His/ Her Name:_____

Relationship:_____

Wk #:_____ Hm#:_____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance company does not cover. A 1 ½ % per month charge will apply to all delinquent accounts.

_____
Signature Date