

THANK YOU . . .

FOR SELECTING OUR DENTAL TEAM



To help us meet all your health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____
Sex: M F Birth Date _____ Age _____ Soc. Sec.# _____ E-mail _____
Street _____ City _____ State _____ Zip _____
Home Tel. (____) _____ Cell. (____) _____ Have you ever been a patient of our practice? Yes No
Medical Doctor _____ Referred by _____
FIRST NAME LAST NAME FIRST NAME LAST NAME
Nearest relative not living with you _____ Tel. (____) _____
FIRST NAME LAST NAME
Employer _____ Bus Tel. (____) _____ Personal Payment Type: Cash Check Credit Card

Who will be responsible for your account? (If self, skip to next section)

Self Spouse Father Mother Other _____
Name _____ Soc. Sec.# _____ Birth Date _____ Age _____ Tel. (____) _____
FIRST NAME LAST NAME
Street _____ City _____ State _____ Zip _____
Employer _____ Bus Tel. (____) _____

Spouse or other guarantor information (If different from above)

Name _____ Relation _____ Soc. Sec.# _____ Birth Date _____
FIRST NAME LAST NAME
Street _____ City _____ State _____ Zip _____
Tel. (____) _____ Employer _____ Bus Tel. (____) _____

INSURANCE INFORMATION

Student: Full Time Part Time Not School Info. _____
SCHOOL NAME ADDRESS
 Married Divorced Legally Separated Widow Single _____
CITY STATE ZIP
Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY

Employer _____ Tel. (____) _____
ADDRESS CITY STATE ZIP
Ins. Co. Name _____ Plan _____
Address _____ Tel. (____) _____
ADDRESS CITY STATE ZIP
Insured Party _____ Relation _____ Group# _____ Group Name _____
FIRST NAME LAST NAME
 M F Birth Date _____ Tel. (____) _____ S.S.# _____ I.D.# _____
Address _____ Tel. (____) _____
CITY STATE ZIP

SECONDARY DENTAL INSURANCE COMPANY

Employer _____ Tel. (____) _____
ADDRESS CITY STATE ZIP
Ins. Co. Name _____ Plan _____
Address _____ Tel. (____) _____
ADDRESS CITY STATE ZIP
Insured Party _____ Relation _____ Group# _____ Group Name _____
FIRST NAME LAST NAME
 M F Birth Date _____ Tel. (____) _____ S.S.# _____ I.D.# _____
Address _____ Tel. (____) _____
CITY STATE ZIP