Patient ID # _____ Date _____

Welcome

Thank you for your visit today! We appreciate you trusting us to care for you dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help you.
We look forward to working with you.

Patient Information

Name_____Home Phone_____
Address _____
City_____State_____Zip Code_____
Sex ☐ Male ☐ Female Age _____
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Social Security Number_____Birth date_____
Occupation_____
Employed by_____
Business Address_____
Work Phone_____
Whom may we thank for referring you?_____
Who may we notify in case of an emergency_____Phone _____

Primary Insurance

Who is responsible for this account?_____
Name _____
Relationship to patient _____Birth date_____Social Security # _____
Address (if different from patient's)_____Phone_____
City_____State_____Zip Code_____
Employed by _____Occupation_____
Business Address_____Work Phone_____
Insurance Company_____
Contract #_____Group #_____Subscriber #_____
Name of other dependents covered by this plan_____

Secondary Insurance

Is Patient covered by additional Insurance? ☐ Yes ☐ No
Subscriber name_____Relationship to patient_____
Address_____Phone_____
City_____State_____Zip Code_____
Subscriber Employed by_____Work Phone_____
Insurance Company _____
Contract #_____Group #_____Subscriber #_____
Name of other dependents covered by this plan_____