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 fill the patient information and insurance forms completely. If you have any questions or need assistance, please give us a call we will be happy to help. We look forward to seeing you at your appointment!

Patient Information

(CONFIDENTIAL)

Mobile #

Soc. Sec. #

Date

Name Birthdate Home Phone

Address City State Zip

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School / College City State Full Time Part Time

Patient's or Parent's Employer Work Phone

Business Address City State Zip

Spouse or Parent's Name Employer Work Phone

Whom May We Thank for Referring You?

Person to Contact in Case of Emergency Phone

Responsible Party

Name of person responsible for this account _relationship to patient

Address Home phone

Driver's License# Birth Date Financial Institution

Employer Work Phone SSN#

Is this person currently a Patient of our Office? Yes No

Insurance Information

Name of insured Relationship to Patient

birthdate Social Security # Date Employed

Employer Union or Local # Work Phone

Employer Address City State Zip

Insurance Company Group # Policy/ID#

Ins. Co. Address City State Zip

How much is your deductible? How much have you used? Max Annual Benefit?

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES COMPLETE THE FOLLOWING:

Name of Insured Relationship to Patient

Birthdate Social Security # Date employed

Employer Union or Local # Work Phone

Employer Address City State zip

Insurance Company Group# Policy/ID#

Insurance Co Address City State Zip

How much is your Deductible How much have you used?Max. Annual Benefit