Welcome

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 of your dental healthcare needs, please fill out this form completely. If you have any questions or needs assistance, please any questions or need assistance, please ask us and we will help.

Patient Information (CONFIDENTIAL)

SS#/SIN _____
Date _____

Name _____ Home Phone _____ Cell Phone _____
Address _____ City _____ State_____ Zip _____
E-Mail _____ Birthdate _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____
Business Address _____ City _____ State _____ Zip _____
Spouse/Guardian's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to contact in case of Emergency _____ Phone _____
Address _____ Relationship _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
E-Mail _____ Birthday _____Cell Phone _____
Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office ? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ Disc. ☐ Amex

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____Union or Local # _____Work Phone _____
Address of Employer _____City _____ State _____ Zip _____
Insurance Company _____Group# _____Policy ID _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Ins. Co. Phone Number _____ *Have you had any other dental work done at another office this year?* Yes/No

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DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS #/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Ins. Co. Phone Number _____