

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 your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
 SS#/SIN _____
 Date _____
 Name _____ Birthdate _____ Home Phone _____
 Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 Email _____ Cell Phone _____
 Check Appropriate Box: Minor Single Married Divorced Widowed Separated
 If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time
 Patient or Parent/Guardian's Employer _____ Work Phone _____
 Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 Spouse or Parent/Guardian'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 _____
 Email _____ Cell Phone _____
 Driver's License # _____ Birthdate _____ Financial Institution _____
 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 in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

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/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 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 _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

