



To help us meet all your healthcare 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 (Confidential)

Patient Name: _____ Last _____ First _____ MI _____ (Preferred Name) _____ Date: _____
Gender: Male Female Birth Date: _____ SSN #: _____ Driver's Lic. #: _____
Address: _____
Phone (Home): _____ (Work): _____ Ext: _____ Fax: _____
E-Mail: _____ Cell Number: _____ Best Time To Call: _____
Check Appropriate Box: Minor Single Married Separated Divorced Widowed
If Student, Name of School/College: _____ City: _____ State: _____
Patient or Parent/Guardian's Employer: _____ Occupation: _____
Employer Address: _____
Date of Last Dental Visit: _____ Reason for Visit: _____
How did hear about our practice? _____
Person to Contact in Case of Emergency: _____ Relationship: _____ 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: _____ SSN #: _____
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 Check Credit Card: VISA MasterCard AmEx I wish to discuss the office's payment policy

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SS#: _____ Date Employed: _____
Employer: _____ Work Phone: _____
Employer Address: _____
Insurance Company: _____ Group #: _____ Policy/ID#: _____
Insurance Co. Address: _____
How Much is Your Deductible? \$ _____ How Much Have You Used? \$ _____ Max. Annual Benefit: \$ _____
Do You Have Any Additional Insurance? Yes No

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SS#: _____ Date Employed: _____
Employer: _____ Work Phone: _____
Employer Address: _____
Insurance Company: _____ Group #: _____ Policy/ID#: _____
Insurance Co. Address: _____
How Much is You Deductible? \$ _____ How Much Have You Used? \$ _____ Max. Annual Benefit: \$ _____
Do You Have Any Additional Insurance? Yes No