WELCOME TO OUR PRACTICE

PATIENT INFORMATION:

Today's Date_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Social Security Number_____

Street_____ Apt._____ City_____ State_____ Zip_____

Home Tel.(_____)_____ Cell.(_____)_____ E-mail_____

Did you find our practice online? ❑ Yes ❑ No Referred By_____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist_____ (FIRST NAME) _____ (LAST NAME) Orthodontist_____ (FIRST NAME) _____ (LAST NAME) Medical Dr._____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.#_____ Nearest relative not living with you_____ (FIRST NAME) _____ (LAST NAME) Tel.(_____)_____

Employer_____ Bus. Tel.(_____)_____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact_____ Tel. (_____)_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ (FIRST NAME) _____ (LAST NAME) S.S.#_____ Birth Date_____ Age_____

Tel.(_____)_____ Cell. (_____)_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Driver's Lic.#_____ Employer_____ Bus. Tel.(_____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ (FIRST NAME) _____ (LAST NAME) Relation_____ S.S.#_____ Birth Date_____

Street_____ Apt._____ City_____ State_____ Zip_____

Tel. (_____)_____ Employer_____ Bus. Tel.(_____)_____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address_____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not. . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

STOP! DETATCH THIS TOP SHEET ONLY, AND BRING IT TO THE FRONT DESK BEFORE PROCEEDING.