

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient #

Employer/School					SS #		
Name					Date		
Address	PATIENT	T INFORMA	ATION				man in the party
Sex   M   F   Married   Widowed   Single   Minor   Separated   Divorced   Partnered for	Name			Birthdate		Home Phone (	)
Separated   Divorced   Partnered for	Address			City		State	Zip
Cell Phone #1   Cell Phone #2   Cell Phone #3   Cell Phone *4   Cell Phone *	Sex M F	☐ Married ☐ Widowed		☐ Single ☐ Minor			
Employer/School Address   City   State   Zip   Spouse or Parent's Name   Employer   Work Phone (		□ Separated	Divorced	☐ Partnered fo	r years		
Employer/School Address	E-mail Cell Phone #			1 ()		Cell Phone #2 ()	
Employer	Employer/School				Employer/School 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 Relation to Patient Address Home Phone ()  Driver's License # Birthdate Bank  Employer Work Phone ()  Currently a patient in our office?   Yes   No   E-mail   Cell Phone ()  INSURANCE INFORMATION  Name of Insured Relation to Patient  Birthdate Social Security # Date Employed  Employer Work Phone ()  Employer Address   City State Zip   Insurance Company Group # Union or Local # AADDITIONAL INSURANCE  ADDITIONAL INSURANCE  Relation to Patient   Date Employed    Birthdate Social Security # Date Employed    Employer Address   City State Zip    How much is your deductible? How much have you used? Max. Annual Benefit    ADDITIONAL INSURANCE  Relation to Patient    Birthdate Social Security # Date Employed    Employer Address   City State Zip    Max. Annual Benefit    ADDITIONAL INSURANCE    Relation to Patient    Birthdate Social Security # Date Employed    Employer Work Phone ()    Employer Address   City State Zip    Insurance Company Group # Union or Local #    Employer Address   City State Zip    Insurance Company   Group # Union or Local #    Address   City State Zip    Insurance Company   Union or Local #    Employer Address   City State Zip    Insurance Company   Union or Local #    Address   City State Zip    Insurance Company   Union or Local #    Insur	Employer/School Add	dress		City		State	Zip
Person to contact in case of emergency Phone ()  RESPONSIBLE PARTY  Name of Person Responsible for this Account Relation to Patient  Address Home Phone ()  Driver's License # Birthdate Bank  Employer Work Phone ()  Currently a patient in our office?   Yes   No   E-mail   Cell Phone ()  INSURANCE INFORMATION  Name of Insured Relation to Patient  Birthdate Social Security # Date Employed    Employer Work Phone ()  Employer Address   City   State   Zip    Insurance Company   Group # Union or Local #    Address   City   State   Zip    How much is your deductible? How much have you used?   Max. Annual Benefit    ADDITIONAL INSURANCE  Relation to Patient    Birthdate   Social Security # Date Employed    Employer   State   Zip    Date Employer   Max. Annual Benefit    ADDITIONAL INSURANCE	Spouse or Parent's N	ame		Employer		Work Phone ()	
RESPONSIBLE PARTY  Name of Person Responsible for this Account Address Home Phone ()  Driver's License #	Whom may we thank	for referring you?					
Name of Person Responsible for this Account	Person to contact in o	case of emergency _			Phone ()		
Relation to Patient Address	RESPON	SIBLE PAI	RTY				
Birthdate	Name of Person Responsible for this A	Account		Relation to Patient			
Employer	Address			Home Phone ()			
Currently a patient in our office?   Yes   No   E-mail   Cell Phone (	Driver's License #			Birthdate		Bank	er .
INSURANCE INFORMATION  Name of Insured	Employer			Work Ph	none ()		
Name of Insured	Currently a patient in	our office?  Yes	☐ No E-mail _			Cell Phone ()	
Name of Insured							
Birthdate	INSURA	ICE INFOI	RMATION				
Employer         Work Phone ()           Employer Address         City         State         Zip           Insurance Company         Group #         Union or Local #	Name of Insured			Relation to Patient			
City	Birthdate Social Securit			y#		Date Employed	
	Employer			Work Ph	one ()		
City	Employer Address	Employer Address		City		State	Zip
How much is your deductible? How much have you used? Max. Annual Benefit	Insurance Company			Group #		Union or Local #	
ADDITIONAL INSURANCE  Name of Insured Relation to Patient Date Employed Employer Work Phone ()  Employer Address City State Zip Address City State Zip St	Address			City		State	_ Zip
Name of Insured         Relation to Patient           Birthdate         Social Security #         Date Employed           Employer         Work Phone ()           Employer Address         City         State         Zip           Insurance Company         Group #         Union or Local #           Address         City         State         Zip	How much is your deductible? How much have			ve you used?		Max. Annual Benefit	
Birthdate         Social Security #         Date Employed           Employer         Work Phone ()           Employer Address         City         State         Zip           Insurance Company         Group #         Union or Local #           Address         City         State         Zip	ADDITIO	ONAL INSU	RANCE				
Employer	ame of Insured Relation to Patient			to Patient			
Employer Address         City         State         Zip           Insurance Company         Group #         Union or Local #           Address         City         State         Zip	Birthdate Social Security			/#		Date Employed	
Insurance Company	Employer			Work Ph	one ()		
Address	Employer Address			City		State	Zip
	Insurance Company			Group #		Union or Local #	
How much is your deductible? How much have you used? Max. Annual Benefit	Address			City		State	Zip
	How much is your deductible? How much have you used? Max. Annual						