WELCOME

DATE: _____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name: _____ Nick Name: _____
Last Name First Name Middle Initial

Social Security #: _____ Home: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Sex: ❑ M ❑ F Age: _____ Birthday: _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by: _____ Occupation: _____

Business Address: _____

Student? YES / NO School: _____ Grade: _____

Person Responsible for account: Last Name: _____ First Name: _____ Middle Initial: _____

Relation to patient: _____ Birthdate: _____ Social Sec#: _____

Address (If different from patient): _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE

Insured Last Name: _____ First Name: _____ Middle Initial: _____

Relation to patient: _____ Birthdate: _____ Social Security #: _____

Address (If different from patient): _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Insured Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Phone: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Name of other dependents under this plan: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name: _____ Relation to patient: _____ Birthday: _____

Address (if different from patient): _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: _____ Phone: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Name of other dependents under this plan: _____