WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

Name: _____
Last First MI

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ___ SS# _____

Home Address: _____

City: _____ State: _____ Zip: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm# _____ Pager# _____

Cell# _____ Other: _____

e-mail address: _____

Wk# _____ Ext _____ DL# _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist _____

Last Visit Date _____

2 Spouse Information

His/Her Name _____

Employer: _____

Wk# _____ Ext: _____ SS# _____

Birthdate: ___/___/___ DL# _____

Person Responsible for Account _____

Wk# _____ Ext: _____ SS# _____

Billing Address _____

Relation: _____ SS# _____

Employer _____ DL# _____

3 Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone# _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthday ___/___/___ **Insured's** SS# _____

Insured's Employer _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name _____

Wk# _____ **Hm#** _____

Continued...