Thank You For Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us and we will be happy to help.

Form #1 - Patient Information

Patient Number

Name

Date

Soc.Sec.# Birthdate Home Phone

Address City State Zip

E-mail Address Sex

If Student, name of City State

Patient's or Parent's Employer Work Phone

Business Address City State Zip

Spouse or Parent 's Name Employer Work 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

Relationschip to Parent

Address Home Phone

Driver's License # Birthdate Financial Institution

Employer Work Phone SSN#

Is this Person Currently a Patient in our Office?

For your convenience, we offer the following methods of payment. Payment in full at each appointment.

Insurance Information

Name of Insured

Relationschip to Parent

Birthdate SSN# Date Employed

Name of Employer Union or Local # Work Phone

Employer Address City State Zip

Insurance Company Group # Policy/ID #

Ins.Co.Address City State Zip

How Much is Your Dedectible? How Much Have You Used? Max.Annual Benefit?

Do You Have Any Additional Insurance ? If yes, Complete the Following

Name of Insured

Relationschip to Parent

Birthdate SSN# Date Employed

Name of Employer Union or Local # Work Phone

Employer Address City State Zip

Insurance Company Group # Policy/ID #

Ins.Co.Address City State Zip

How Much is Your Dedectible? How Much Have You Used? Max.Annual Benefit?