

# W E L C O M E

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 questions we'll be glad to help you.  
We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Email \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

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 \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.

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Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_  
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Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_

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City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

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Please complete both sides.