Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please print clearly and fill out this form completely. If you have any questions or need assistance, please ask us- we will be happy to help you.

Date_____

Name: First _____ MI_____ Last _____

Wishes to be Called _____

Mailing Address _____

Residential Address _____

City _____State_____ Zip Code _____

Home Phone _____ Work_____ Cell_____

Which number is best to reach you during work hours? _____

Birth Date _____ Sex _____Marital Status_____

Social Security # _____Full Time Student? _____

Name of School/College _____

Occupation _____Employer_____

Person to Contact in Case of Emergency_____ Phone_____

Whom May We Thank for Referring You? _____

Responsible Party

Name_____ Relationship to Patient_____

Address _____Home Phone _____

Social Security #_____ Birth date _____

Employer _____Work Phone _____

Dental Insurance Information

Please Have Your Insurance Card Ready

Name of Insured _____Relationship to Patient_____

Birth Date_____ Social Security # _____

Name of Employer _____ Work Phone _____

Address of Employer _____

Insurance Company _____ Group #_____

Insurance Co. Address _____

Do You Have Additional Dental Insurance? _____

Authorization And Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payments for services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent if minor)