WELCOME

Patient Information

Last Name:_____ First Name:_____ MI:_____
Sex: ____Male ____Female Birth Date:_____/_____/_____ Age:_____ SocSec#:_____ Drivers Lic:_____
Address:_____ City/State:_____ Zip:_____
Home Phone:(____)_____Work Phone:(____)_____ Ext:_____ Cell Phone:(____)_____
E-mail:_____ Yes / No I would like to receive correspondences via e-mail.
Employer:_____ How Long?_____
Employer Address:_____ City/State:_____ Zip:_____
Occupation:_____
Marital Status:___ Minor ___Single ___ Married ___ Divorced ___ Separated ___ Widowed
Spouse's Name:_____ Do you have children? Yes / No How Many?_____
How did you hear about us?_____

Primary Dental Insurance Information

Name of Insured:_____ Your relationship to Insured:___ Self ___ Spouse ___ Child ___ Other
Insured Soc Sec#:_____ Insured Birth Date:_____/_____/_____
Insurance Co Name:_____ Insurance Co Phone:(_____)_____
Insurance Co Address:_____ City/State:_____ Zip:_____
Insured's ID#:_____ Group# (Plan, Local, or Policy#):_____

Secondary Dental Insurance Information

Name of Insured:_____ Your relationship to Insured:___ Self ___ Spouse ___ Child ___ Other
Insured Soc Sec#:_____ Insured Birth Date:_____/_____/_____
Insurance Co Name:_____ Insurance Co Phone:(_____)_____
Insurance Co Address:_____ City/State:_____ Zip:_____
Insured's ID#:_____ Group# (Plan, Local, or Policy#):_____

Your MEDICARE # _____

Primary Medical Insurance Information

Company Name _____ HMO or PPO (please circle one)
ID#_____ Group#_____

Secondary Medical Insurance Information

Company Name _____ HMO or PPO (please circle one)
ID#_____ Group#_____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am Solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any required information to process the insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my Responsibility to inform this office of any changes to the information I have provided.

Signature_____ **Date**_____

___Adult Patient ___Parent or Guardian