THANK YOU . . .
FOR SELECTING OUR DENTAL TEAM

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

PATIENT INFORMATION

❑Mr. ❑Mrs. ❑Ms. ❑Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑M ❑F Birth Date _____ Age _____ Soc. Sec.# _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (____) _____ Cell. (____) _____ Have you ever been a patient of our practice? ❑Yes ❑No

Medical Doctor _____ _____ Referred by _____ _____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Nearest relative not living with you _____ _____ Tel. (____) _____
FIRST NAME LAST NAME

Employer _____ Bus Tel. (____) _____ Personal Payment Type: ❑Cash ❑Check ❑Credit Card

Who will be responsible for your account? *(If self, skip to next section)*

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ _____ Soc. Sec.# _____ Birth Date _____ Age ____ Tel. (____) _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Employer _____ Bus Tel. (____) _____

Spouse or other guarantor information *(If different from above)*

Name _____ _____ Relation _____ Soc. Sec.# _____ Birth Date _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Tel. (____) _____ Employer _____ Bus Tel. (____) _____

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School Info. _____
SCHOOL NAME ADDRESS

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____ _____ _____
CITY STATE ZIP

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY

Employer _____ _____ _____ _____ _____ Tel. (____) _____
ADDRESS CITY STATE ZIP

Ins. Co. Name _____ Plan _____

Address _____ _____ _____ _____ Tel. (____) _____
ADDRESS CITY STATE ZIP

Insured Party _____ _____ Relation _____ **Group#** _____ **Group Name** _____
FIRST NAME LAST NAME

❑ M ❑ F Birth Date _____ Tel. (____) _____ S.S.# _____ I.D.# _____

Address _____ _____ _____ _____ Tel.(____) _____
CITY STATE ZIP

SECONDARY DENTAL INSURANCE COMPANY

Employer _____ _____ _____ _____ _____ Tel. (____) _____
ADDRESS CITY STATE ZIP

Ins. Co. Name _____ Plan _____

Address _____ _____ _____ _____ Tel. (____) _____
ADDRESS CITY STATE ZIP

Insured Party _____ _____ Relation _____ **Group#** _____ **Group Name** _____
FIRST NAME LAST NAME

❑ M ❑ F Birth Date _____ Tel. (____) _____ S.S.# _____ I.D.# _____

Address _____ _____ _____ _____ Tel.(____) _____
CITY STATE ZIP