Welcome to The Dentists' Office

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 you dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information (CONFIDENTIAL)

Date_____

NAME_____ Birthdate_____ Home Phone_____

Address_____ City_____ State/Zip_____

Email (optional)_____ Cell Phone_____ Soc. Sec. #_____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's Employer_____ Work Phone_____

Business Address_____ City_____ State/Zip_____

Spouse or Parent/Guardian's Name_____ Work Phone_____

Spouse or Parent/Guardian's Employer_____ City_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency (living in same home)_____ Phone_____

Person to Contact in Case of Emergency (not living in same home)_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Email (optional)_____ Cell Phone_____

Driver's License #_____ Birthdate_____ SSN_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? ❑ Yes ❑ No Are there other family members? ❑ Yes ❑ No

For your convenience, we offer the following methods of payment. Please check the option you prefer:

❑ Cash ❑ Personal Check Credit Card: ❑ VISA ❑ MasterCard ❑ Care Credit

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN_____ DateEmployed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ Yes ❑ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____