WELCOME

We are pleased to welcome you to our practice. Please take a few minutes and fill out this form completely. If you have questions we'll be glad to assist you. We look forward to working with you in maintaining you dental health.

Adult Patient Information

Date ____________________

Name ____

Last Name First Name Initial Preferred

Address ____

Street Apt # City State Zip

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Sex ❐ M ❐ F **Birthdate** __________ ❐ Single ❐ Married ❐ Widowed ❐ Separated ❐ Divorced

Soc. Sec # ____________________ Drivers License # ____________________

Patient E-Mail Address ____

Patient Employed by ____________________ Occupation ____________

Spouse Name ____________________ Spouse Birthdate ____________

Spouse Employed By ____

Referral

Whom may we thank for referring you to our practice? ❐ Another Patient ❐ Previous Patient
❐ Dental Office ❐ Yellow Pages ❐ Newspaper ❐ School ❐ Work
Name of person, or office referring you to our practice: ____________________

Insurance

Do you have ***dental*** insurance coverage? Yes No

Primary Insured's Name ____________________

Address (if different from patient) ____________________

____

Employer/Plan Name ____________________

Soc. Sec. # ____________ Birthdate ____________

Ins. Company ____________________

Ins. Phone #: ____________________

Primary Insured's Name ____________________

Address (if different from patient) ____________________

____

Employer/Plan Name ____________________

Soc. Sec. # ____________ Birthdate ____________

Ins. Company ____________________

Ins. Phone #: ____________________

Emergency Contact

In the event of an **emergency**, please list contact not residing with you.
Name ____________________ Relationship ____________ Phone ____________