

# WELCOME

# 1

## ABOUT YOU

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First MI

What You Prefer to be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Home Phone #: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_  
Other Phone #s: \_\_\_\_\_

May we contact you at work? Yes No If not, where? \_\_\_\_\_

E-mail address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Occupation: \_\_\_\_\_

Status:  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

# 2

## INSURANCE INFO

### Primary Dental Insurance

Co. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local, or policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

### Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City State Zip

Phone #: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

# 3

## ACCOUNT INFO

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

City State Zip

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Payment method:  Cash  Check  Credit Card

I fully understand that I am solely responsible

*initials*

for any charges incurred on behalf of this patient. If dental benefits apply to any treatment, I understand that the obligation of payment is between myself and my insurance company.

# 4

## IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

M.D.'s Phone #: \_\_\_\_\_