


WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you. 

1 ABOUT YOU

Today's Date:

E-mail Address:

Name:

LAST FIRST MI MR MRS MS DR

I prefer to be called: Male Female

Birthdate: Age: SS #:

Home Address:

APT / CONDO #

CITY STATE ZIP

Single Married Divorced Widowed Separated

Hm #: Pager / Cell #:

Wk #: Ext: DL #:

Employer:

Employer's Address:

How long there? Occupation:

Where & when are best times to reach you?

Whom may we Thank for referring you?

Other family members seen by us:

Previous / Present Dentist:

(Please Circle)

Last Visit Date:

2 SPOUSE INFORMATION

His / Her Name:

Employer:

Wk #: Ext: SS #:

Birthdate: DL #:

Person Responsible for Account:

Wk #: Ext: Hm #:

Billing Address:

Relation: SS #:

Employer: DL #:

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthdate: Insured's ID #:

Insured's Employer:

Employer's Address:

Secondary Dental Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthdate: Insured's ID #:

Insured's Employer:

Employer's Address:

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: Relation:

Wk #: Hm #:

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name:

Wk #: Date of last visit:

Are you currently under the care of a physician? Yes No

Please Explain:

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