

# Welcome

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

## Patient Information

Date \_\_\_\_\_ PL. # \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Name \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependants covered under this plan \_\_\_\_\_

## Additional Insurance

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Contract \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

Please Complete Both Sides