Welcome!

Thank you for choosing our office. Our mission is to provide our patients with personalized, comfortable, high quality dental care and education which will result in lasting oral health and esthetics.

Patient Information (Confidential)

Name: _____ Parent/Guardian _____

Last name *First name* *Last name* *First name*

Date of Birth _____ Sex _____ Age _____ Soc. Sec. # _____

Home Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email _____ Drivers License # _____

Employer _____Occupation _____ How long there? ____ May we call? _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Name (Or other parent/guardian) _____ Soc. Sec. # _____

Employer _____ Occupation _____ How long there? ____ May we call? _____

Employer Address _____ City _____ State _____ Zip _____

Are you a student? □Yes □ No

Name of School/College: _____ City & State _____ □ Full time □ Part time

How did you hear about our practice? _____

Primary Insurance:	***Additional Insurance:***
Name of Insured _____	Name of Insured _____
Date of Birth _____ Relationship _____	Date of Birth _____ Relationship _____
Address _____	Address _____
Insurance Co. _____ Phone _____	Insurance Co. _____ Phone _____
Soc. Sec. # _____ ID # _____	Soc. Sec. # _____ ID # _____
Group/Contract/Local/Union # _____	Group/Contract/Local/Union # _____

In case of Emergency:

Name and City of primary care physician _____

Someone we may contact, not living with you: _____ Phone #'s _____