ATLA DENTAL, INC.

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 care for you.

About You

Today's Date _____

Name: _____
LAST FIRST M.I. MR. MRS. MS. DR.

I prefer to be called _____ ☐ Male ☐ Female

Birthdate____/____/____Age____SS# _____

Home Address: _____

_____ APT. /CONDO# _____

_____
CITY STATE ZIP

Email: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home # _____ Pager/Other # _____

WK # _____ Ext. _____ DL # _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation _____

Where & When is the best time to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous / present Dentist: _____
(Please circle)

Last visit date? _____

Spouse Information

NAME: _____

Employer _____

WK #: _____ Ext. _____ SS# _____

Birthdate: _____ DL# _____

_____

Person Responsible for Account: _____

Wk# _____ Ext. _____ HM# _____

Billing Address: _____ Zip: _____

Relationship: _____ SS# _____

Employer: _____ DL# _____

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 Birthday:____/____/____Insured SS # _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____ Relation: _____

Insured's Birthday:____/____/____Insured SS # _____

Insured's Employer: _____

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

Their Name: _____ Relation: _____

WK# _____ HM# _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone#: _____ Date of last visit: _____