

# 🦷 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 \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Alt. Phone (\_\_\_\_) \_\_\_\_\_  
Name \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_  
Last Name First Name Middle Initial  
Address \_\_\_\_\_ E-mail \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## 🦷 Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ ID#/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 dependents 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