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.

About You

Today's Date: ____/____/_____

Name: _____ _____ I prefer to be called: _____
Last First

□Male □ Female Birthdate: ____/____/_____ Social Security #: _____-_____-_____

Home Address: _____
Street

_____ _____ _____
City State Zip

□ Single □ Married □ Divorced □ Widowed □ Separated

Home#: (_____) _____-_____ Cell #: (_____) _____-_____

Work #: (_____) _____-_____

Email Address: _____

Whom may we thank for referring you? _____

*****If the individual responsible for this account is different than the information above please fill out the form below*****

Name of Person Responsible for Account: _____ _____
Last First

Billing Address: _____
Street

_____ _____ _____
City State Zip

Home#: (_____) _____-_____ Cell #: (_____) _____-_____

Work #: (_____) _____-_____

Relationship to Patient: _____

Primary Dental Insurance Coverage

Policy Holder's Name: _____ _____ Relationship to Patient: _____
Last First

Insurance Company Name: _____

Billing Address: _____
Street

_____ _____ _____
City State Zip

Phone #: (_____) _____-_____

Group # (Plan, Local or Policy#): _____

Policy Holder's Subscriber#: _____

Policy Holder's Employer: _____

Policy Holder's Social Security Number: _____-_____-_____

Policy Holder's DOB: ____/____/_____

Secondary Dental Insurance Coverage

Policy Holder's Name: _____ _____ Relationship to Patient: _____
Last First

Insurance Company Name: _____

Billing Address: _____
Street

_____ _____ _____
City State Zip

Phone #: (_____) _____-_____

Group # (Plan, Local or Policy#): _____

Policy Holder's Subscriber#: _____

Policy Holder's Employer: _____

Policy Holder's Social Security Number: _____-_____-_____

Policy Holder's DOB: ____/____/_____