PATIENT INFORMATION

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we are happy to help.

DATE _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank you for referring you? _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY

Name _____ Relationship to patient _____

Address _____ Home Phone _____

Birthdate _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

NOTE: Financial Policy must be reviewed and signed by responsible party / guarantor.

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security N°. _____ Date Employed _____

Name of employer _____ Union or Local N°. _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group N°. _____ ID N°. _____

Insurance Company Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Do you have additional insurance? ☐ **Yes** ☐ **No** *If yes, complete the following:*

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security N°. _____ Date Employed _____

Name of employer _____ Union or Local N°. _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group N°. _____ ID N°. _____

Insurance Company Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

NOTE: Provide copy of insurance card. If covered by multiple insurance policies, please provide a card for each policy.