



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

***Patient Information (CONFIDENTIAL)**

Name _____ DOB ____/____/____ SSN ____ - ____ - ____ DL# _____

Address _____ City/ State _____

Home Phone # _____ Cell Phone _____ email _____

Patients Employer _____ Work Phone _____

Marital Status

***How did you hear about our practice?**

____ Minor ____ Divorced

____ Phone Book ____ Drive By

____ Single ____ Widowed

____ Magazine Ad ____ Post card

____ Married ____ Separated

____ Referral _____

Person to contact in case of Emergency _____

Phone # _____ Relationship _____

Responsible Party (if different than patient)

Name of Person Responsible for the account _____ DOB ____/____/____

Address _____ City/State _____

DL# _____ SSN ____ - ____ - ____ Relationship to Patient _____

Employer _____ Work Phone # _____

***Insurance Information (much of this information can be found on the insurance card)**

Name of the Insured _____ DOB ____/____/____

Employer _____ Group # _____ ID# _____

Business Address _____ Work Phone _____

Insurance Company _____ Phone # _____

Insurance Company Address _____

Patient or Guardian Signature

Date