

# Welcome to The Dentists' Office

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 will be happy to help!

## Patient Information (CONFIDENTIAL)

Date \_\_\_\_\_  
NAME \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Email (optional) \_\_\_\_\_ Cell Phone \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Spouse or Parent/Guardian's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Spouse or Parent/Guardian's Employer \_\_\_\_\_ City \_\_\_\_\_  
Whom May We Thank for Referring You? \_\_\_\_\_  
Person to Contact in Case of Emergency (living in same home) \_\_\_\_\_ Phone \_\_\_\_\_  
Person to Contact in Case of Emergency (not living in same home) \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email (optional) \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No Are there other family members?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer:

Cash  Personal Check Credit Card:  VISA  MasterCard  Care Credit

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy ID # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  Yes  No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy ID # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_