WELCOME!

Who may we thank for referring you: _____

Patient Information

Name: _____ Nickname: _____ Male Female
Last First MI

Birth Date: _____/_____/_____Age: _____ SS#: _____-_____-_____ Home #: (_____)_____-_____

Address:_____
Street City State Zip

Previous/Present Dentist: _____ Date of Last Visit:_____ Date of Last Exam: _____

Why did you leave your previous dentist? _____

Reason for today's visit: _____ Any problems with previous dental visits: _____

Is this your child's first dental visit? yes no

Parent Information (if patient is a minor)

Parent's Marital Status: Married Divorced Single Widowed Partnered Separated

Mother's Information: Stepmother Guardian

Name: _____ Birth Date: _____

Home #: _____Cell #: _____Work# _____

Address:_____
Street

_____
City State Zip

SS #: _____ Driver's License #: _____

E-mail: _____
Responsible for account Responsible for making appointments

Father's Information: Stepfather Guardian

Name: _____ Birth Date: _____

Home #: _____ Cell #: _____ Work #: _____

Address:_____
Street

_____
City State Zip

SS #: _____ Driver's License #: _____

E-mail: _____
Responsible for account Responsible for making appointments

Insurance Information

Primary Dental Insurance
Insurance Company Name: _____

Insurance Company Phone #: _____

ID #_____Group # _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: _____ SS #: _____

Policy Owner's Employer:_____

Employer's Address:_____

Secondary Dental Insurance
Insurance Company Name: _____

Insurance Company Phone #: _____

ID #_____Group # _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: _____ SS #: _____

Policy Owner's Employer:_____

Employer's Address:_____