

# WELCOME!

Thank you for choosing our office. We strive to provide you with the gentlest, quality care possible.  
If you have any questions, or we can help you in any way, please feel free to ask.

## Patient Information (Confidential):

Name \_\_\_\_\_ (If child, parent/guardian name) \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
E-Mail \_\_\_\_\_ Drivers License # \_\_\_\_\_  
How did you hear about our practice? \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How long there? \_\_\_\_\_ May we call? \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse's Name (Or other parent/guardian) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How long there? \_\_\_\_\_ May we call? \_\_\_\_\_  
Spouse's Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
If patient is a student: Name of school/college: \_\_\_\_\_ City & State \_\_\_\_\_ Full time or part time? \_\_\_\_\_

## Primary Insurance/Additional Insurance:

Name of Insured _____	Name of Insured _____
Birthdate _____ Relationship to patient _____	Birthdate _____ Relationship to patient _____
Address (if different from patient) _____	Address (if different from patient) _____
Dental Insurance Co. _____ Phone _____	Dental Insurance Co. _____ Phone _____
Social Security # _____ Subscriber ID # _____	Social Security # _____ Subscriber ID # _____
Group, Contract or Local or union # _____	Group, Contract or Local or union # _____

## In Case of Emergency:

Name and City of primary care physician \_\_\_\_\_  
Someone we may contact, not living with you: \_\_\_\_\_ Phone #'s (home, work, cell) \_\_\_\_\_

## Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Responsible Party