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 complete our form.
If you have any questions or need assistance, please ask us
We will be happy to help.

## Patient Information (CONFIDENTIAL)

Home Phone #__________________
Cell Phone# __________________
Work Phone#__________________
Email ______________________

Name__________________________ Birthdate_____________ Social Security#________________
Address____________________________________ City__________________ Zip __________
If College Student Name of School__________________Address______________________________
Patient's or Parent's Employer____________________________________Phone#________________
Employers Address______________________________ Employee's Social Security#______________
Person to Contact in Case of Emergency__________________________ Phone #________________
Best way to reach you during office hours_________________________________

## Responsible Party

IF a minor,
Name of person Responsible for this Account ___________________________ Relationship to Patient __________
Address__________________________ City_____________ Zip_______Phone #_______________
Employer ______________________Work Phone#____________Social Security#________________
Driver's License#_________________ Is This Person Currently a Patient in our Office?______________

## Insurance Information

Name of Insured________________________ Social Security #____________ Relationship to Patient___________
Date of Birth_________ Employer________________Address_______________________________
Employer phone#___________ Insurance Company ____________________Group/Policy #_________
Insurance Phone Number_________________________ Employee ID#__________________________
Have you used any of your insurance for this year?_________________

Do You Have Any additional Insurance? If so complete below.

Name of Insured________________________ Social Security #____________ Relationship to Patient___________
Date of Birth_________ Employer________________Address_______________________________
Employer phone#___________ Insurance Company____________________Group/Policy #_________
Insurance Phone Number_________________________Employee ID#__________________________

Whom May We Thank for Referring You?______________________________________________