Welcome

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 # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____

Home Phone _____

State/Prov. _____ Zip/P.C. _____

Address _____ City _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

State/Prov. _____ ☐ Full Time ☐ Part Time

If Student, Name of School/College _____ City _____

Patient or Parent/Guardian's Employer _____

Work Phone _____

State/Prov. _____ Zip/P.C. _____

Business Address _____ City _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____

Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____

Work Phone _____ State/Prov. _____ Zip/P.C. _____

Address of Employer _____ City _____

Insurance Company _____ Group# _____

Policy/ID# _____ State/Prov. _____ Zip/P.C. _____

Ins. Co. Address _____ City _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

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

Name of Insured _____

Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____

Work Phone _____ State/Prov. _____ Zip/P.C. _____

Address of Employer _____ City _____

Insurance Company _____ Group# _____

Policy/ID# _____ State/Prov. _____ Zip/P.C. _____

Ins. Co. Address _____ City _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please