Welcome!

Thank you for choosing our office for your dental needs. We are committed to helping you maintain good dental health. Please fill out this form and return it to our office prior to your first visit. This form will help us to get to know you better and will be kept confidential. If you have any questions or concerns, please ask. We will be happy to help. (Please Print)

Patient Information

Name_____ Birthdate _____ Age:_____

Address_____ City_____State/Zip_____

Home #_____ Work #_____ Cell #_____

Email (for appointment communication, newsletters, etc) _____

Do you Prefer to receive reminders at: Home Work Cell Text Message Email

Occupation_____ Employer_____

Business Address_____ State/Zip_____

Other family members who are patients here: _____

Whom may we thank for referring to us? _____

People to contact in case of emergency: _____

Closest Relative_____Phone #_____Relation_____

Nearest Neighbor_____Phone #_____

Responsible Party

If you are under age 26, name of parent/ guardian_____

Parent's Home #_____ Work #_____ Cell #_____

Who is responsible for payment for treatment? Self or Other (circle one)

If someone other than self is responsible for payment, please complete this section:

Name: _____ Birthdate: _____

Relationship to patient_____Phone #_____Cell #_____

Address_____City_____State/Zip_____

Name of employer_____Work#_____

I understand that payment is due on date of treatment. I understand that any balance overdue may be subject to a 10% APR finance charge and agree to the terms as described in the office guide.

Signature_____Date_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: Yes or No (if No, you may skip this page)

Name of Insured_____Relationship to patient_____

Birthdate_____ Insurance Co._____Insurance ID #_____

Name of employer_____Work #_____

Address_____City_____State/Zip_____

Insur Co. Address_____City_____State/Zip_____

How much is your annual deductible?_____Coverage period _____Max. Annual benefit_____

DO YOU HAVE ADDITONAL DENTAL INSURANCE? NO YES

Secondary Dental Insurance Information

Name of Insured_____ Relationship to patient_____

Birthdate_____ Insurance Co._____Insurance ID #_____

Name of employer_____Work #_____

Address_____City_____State/Zip_____

Insur. Co. Address_____City_____State/Zip_____

How much is your annual deductible?_____Coverage period _____Max. Annual benefit_____

I authorize and request that my insurance company pay directly to the dental office any insurance benefits otherwise payable to me. I understand that my dental benefits may not cover the entire bill for services. I accept personal responsibility for the balance of any fee where a service is only partially covered by the insurance company. I understand that my balance will be due prior to receiving the insurance payment, as described in the office guide. I understand that any balance overdue may be subject to a 10% APR finance charge and agree to the terms as described in the office guide.

Signature_____Date_____