Welcome

Please fill out this form completely, it is important to your care.

ABOUT YOU

Today's Date: ______________ ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Name: ______________ (LAST FIRST MI) ☐ M ☐ F Birthdate: ___/___/___ Age: _____ SS#: ______________

Home Address: ______________ (CITY STATE ZIP)

Hm #: (_____) ______________ Cell #: (_____) ______________ Wk #: (_____) ______________ DL #: ______________

E-Mail Address: ______________ When are the best times to reach you? ______________

Whom may we thank for referring you? ______________ Other family members seen by us: ______________

Employer: ______________ How long there? ______________ Occupation: ______________

Employer's Address: ______________ (CITY STATE ZIP)

General Doctor: ______________ Previous or Present (Please circle) Date of last visit: ______________

In the event of an emergency, whom should we contact?

His/Her Name: ______________ Relation: ______________ Wk #: (_____) ______________

Hm #: (_____) ______________ Address: ______________ (CITY STATE ZIP)

SPOUSE INFORMATION

His/Her Name: ______________ Birthdate: ___/___/___ SS #: ______________

Employer: ______________ Wk #: (_____) ______________ DL #: ______________

Person Responsible for Account, if other than yourself

Name: ______________ Relation: ______________ SS #: ______________

Employer: ______________ Wk #: (_____) ______________ DL #: ______________

Hm #: (_____) ______________ Billing Address: ______________

INSURANCE INFORMATION

Primary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: ______________ Ins. Co. Ph #: (_____) ______________ Group # (Plan, Local or Policy #): ______________

Insurance Co. Address: ______________ (CITY STATE ZIP)

Insured's Name: ______________ Relation: ______________ Insured's Birthdate: ___/___/___ SS #: ______________

Insured's Employer: ______________ Employer's Address: ______________ (CITY STATE ZIP)

Secondary Insurance Dental Coverage: ☐ Y ☐ N Medical Coverage: ☐ Y ☐ N Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: ______________ Ins. Co. Ph #: (_____) ______________ Group # (Plan, Local or Policy #): ______________

Insurance Co. Address: ______________ (CITY STATE ZIP)

Insured's Name: ______________ Relation: ______________ Insured's Birthdate: ___/___/___ SS #: ______________

Insured's Employer: ______________ Employer's Address: ______________ (CITY STATE ZIP)