



## **Welcome**

We are pleased to have you as a guest in our practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, please feel free to ask. We look forward to being of service to you.

### **Patient Information:**

Name: \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: M F Marital Status: Single Married Widowed Separated Divorced

Patient employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

How do you plan to pay for today's visit? \_\_\_\_\_ Cash/Check \_\_\_\_\_ MC/Visa/Debit

### **Dental Insurance:**

Person responsible for account: \_\_\_\_\_  
Last name First name Initial

Relationship to patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Responsible party's employer: \_\_\_\_\_ Business phone: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Phone number: \_\_\_\_\_

Group number: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Name of other dependants under this plan: \_\_\_\_\_

### **Please complete below if patient is a minor (under 18 years):**

Mother's Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Work phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Work phone: \_\_\_\_\_