Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible 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 Information (Confidential)

Today's date _____

Name_____ Birthdate_____ Social Security _____

Address _____ City _____ Zip code _____

Phone number _____ Email _____

Patient employer _____

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

Emergency contact _____ Relation_____ Phone number_____

Whom may we thank for referring you to our office? _____

If Student, Name of School/ College	If Minor, Parent / Guardian Name
_____	_____
City _____ State _____	Employer _____
❒ Part time ❒ Full time	Phone number _____

Responsible Party (for minors)

Name _____ Relationship _____ Phone number _____

Address (if different from above) _____ City _____ State _____ Zip Code _____

Insurance *required

I have dual insurance ❒ YES ❒ NO

*Primary Insurance Company _____	*Secondary Insurance Company _____
Insurance phone number _____	Insurance phone number _____
*Subscriber employer_____	*Subscriber employer_____
*Subscriber name _____	*Subscriber name _____
*Birth Date ____/____/____ *Social Security #_____	*Birth Date ____/____/____ *Social Security #_____
*Insurance ID# _____ Group # _____	*Insurance ID# _____ Group # _____
Relation to subscriber _____	Relation to subscriber _____