

# WELCOME TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

## PATIENT INFORMATION

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_  
Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Who should we thank for referring you? \_\_\_\_\_  
In case of emergency, who should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## ADDITIONAL INSURANCE

Insured Name \_\_\_\_\_  
Last Name First Name Initial  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insured Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Please complete reverse side

