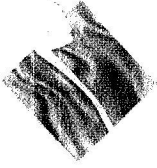
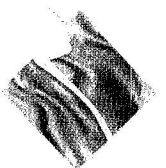


Patient I.D. # \_\_\_\_\_

# WELCOME



*Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you!*



## PATIENT INFORMATION

Date \_\_\_\_\_ Home phone \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Divorced  Separated

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Business address \_\_\_\_\_ Work phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Whom may we notify in case of an emergency? \_\_\_\_\_ Phone \_\_\_\_\_

## PRIMARY INSURANCE

Who is responsible for this account? \_\_\_\_\_

Name \_\_\_\_\_

Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business address \_\_\_\_\_ Work phone \_\_\_\_\_

Insurance company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered by this plan \_\_\_\_\_

## SECONDARY INSURANCE

Is patient covered by additional insurance?  Yes  No

Subscriber name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Subscriber employed by \_\_\_\_\_ Work phone \_\_\_\_\_

Insurance company \_\_\_\_\_ Social Security # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered by this plan \_\_\_\_\_

*Please Complete Both Sides*