

Welcome *Thank you for selecting our healthcare team!!*

Patient Information (Confidential)

Date _____

Name _____ Male/Female _____ Preferred/nickname _____

Age _____ Birthdate _____ Soc. Security # _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

E-Mail address _____ Occupation _____

Patient's Employer _____ Work Phone (____) _____

Person to contact in case of emergency _____ Relationship _____

Daytime phone (____) _____

If student, name of School/College _____ City _____ State _____

Parent's name _____ Parent's Employer _____

Parent's work number (____) _____

Whom may we thank for referring you? _____

Do you or someone you live with snore? Yes No

Dental Insurance Information

Name of Insured _____ Relationship to patient _____

Insured's Date of Birth _____ Is Insured a patient at our office? _____

Social Security # of Insured _____

Insured's Employer _____ Work Phone (____) _____

Insurance Company _____ Group # _____ Policy/ID _____

Do you have any additional dental insurance? Yes No *If so, please complete the following:*

Name of insured _____ Relationship to patient _____

Insured's Date of Birth _____ Is Insured a patient at our office? _____

Social Security # of Insured _____

Insured's Employer _____ Work Phone (____) _____

Insurance Company _____ Group # _____ Policy/ID _____