



# Welcome



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.



## Patient Information

Date	Home Phone ( )	Cell Phone ( )
Name	SS/HIC/Patient ID #	
Last Name	First Name	Middle Initial
Address	E-mail	
City	State	Zip
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age	Birthdate	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor
		<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for years
Patient Employer/School	Occupation	
Employer/School Address	Employer/School Phone ( )	
Whom may we thank for referring you?		
In case of emergency who should be notified?	Phone ( )	



## Primary Insurance

Person Responsible for Account	Last Name	First Name	Middle Initial
Relation to Patient	Birthdate	Soc. Sec. #	
Address (If different from patient's)	Phone ( )		
City	State	Zip	
Person Responsible Employed by	Occupation		
Business Address	Business Phone ( )		
Insurance Company			
Contract #	Group #	Subscriber #	
Names of other dependents covered under this plan			



## Additional Insurance

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Subscriber Name	Birthdate	Relation to Patient
Address (If different from patient's)	Phone ( )	
City	State	Zip
Subscriber Employed by	Business Phone ( )	
Insurance Company	Soc. Sec. #	
Contract #	Group #	Subscriber #
Names of other dependents covered under this plan		