WELCOME!

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to ask.

Patient Information

Name_____
Last First Middle Initial

Address_____Phone_____

City_____ State_____ Zip Code_____

Sex □F □M □Non-Binary Age_____ Birth date_____ Soc. Sec._____-_____-_____

Email Address (for appointment reminders, no marketing or sharing of information):_____

Employer_____ Business Phone_____

Business Address_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone_____

Primary Insurance Information

Person Responsible for Account_____
Last First Middle Initial

Relation to Patient_____ Birth date_____ Soc. Sec._____-_____-_____

Address (if different from patients) _____ Phone_____

City_____ State_____ Zip Code_____

Person Responsible Employed by_____ Business Phone_____

Insurance Company_____

Contact #_____ Group #_____ Subscriber #_____

Secondary Insurance Information

Is patient covered by additional insurance? _____

Person Responsible for Account_____
Last First Middle Initial

Relation to Patient_____ Birth date_____ Soc. Sec._____-_____-_____

Person Responsible Employed by_____ Phone_____

Insurance Company_____

Contact #_____ Group #_____ Subscriber #_____

PRIVACY POLICY:

By signing below, you acknowledge that you have read and understand this office's Notice of Privacy Practices.

Signature_____ Date_____