Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely.

Patient Information

Name _____ _____ _____ Birthdate_____/_____/_____
First Middle Last

Preferred Name:_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____ Work_____ ext._____

Drivers License #_____ E-mail _____ Do you Text? ☐ yes ☐ no

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married If Minor, Parent's Name_____

Patient's or Parent's Employer_____ Work Phone _____ ext._____

Employer's Address_____ City_____ State_____ Zip_____

Spouse's Name_____ Employer_____ Work Phone _____

Person to contact in case of Emergency _____ Phone #_____

Whom may we thank for referring you?_____

Responsible Party

Name of Person Responsible for this Account _____ ☐ Self ☐ Parent/Legal Guardian ☐ Spouse

Is this person currently a patient in our office ☐ yes ☐ no

If Responsible party is not the patient, please provide the following:

Birthdate_____/____/_____ Social Security #_____/____/_____ Driver's License # _____

Address_____ City _____ State _____ Zip_____ Home Phone_____

Employer_____Address_____ _____ Work Phone_____

Dental Insurance Information

Name of Insured_____ Relationship to patient: ☐ Self ☐ Parent/Legal Guardian ☐ Spouse

Birthdate of Insured_____/_____/_____ Social Security # of insured_____/_____/_____

Name of Employer_____ Work Phone_____ ext._____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ ID#_____

Insurance Company Address_____ City_____ State_____ Zip _____