1Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU			
Today's Date:			
E-mail Address:			
Name:			
I prefer to be called:			
Birthdate:/			
Home Address:			
Apt/Condo #			
City State Zip ☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed			
Hm #: (Cell #:			
Wk #: (
Employer:			
Employer's Address:			
City State Zip			
How long there? Occupation:			
Where & when are best times to reach you?			
Whom may we Thank for referring you?			
Other family members seen by us:			
Previous / Present Dentist:			
(Pleose Circle)			
Person Responsible for Account:			
Sponse information			
His / Her Name:			
Employer:			
Contact #: () Ext: SS #:			
Birthdate:// DL #:			
Relative or Friend not living with you (for emergency).			
His / Her Name: Relation:			
Contact #: (

2 INSURANCE		
Primary Insurance	SCENE PROCESSOR SOCIETATION AND ADMINISTRATION AND	
Dental Coverage? Yes No		
Insurance Co. Name:		
Insurance Co. Address:		
City State Insurance Co. Phone #: ()	Zip	
Group # (Plan, Local or Policy #):		
Insured's Name: Relation:		
Insured's Birthdate:/ Insured's ID #:		
Insured's Employer:		
Employer's Address:		
Employer's Address.		
City State	Zip	
Secondary Insurance		
Secondary Insurance Dental Coverage? Yes No		
Dental Coverage? Yes No		
Dental Coverage? Yes No Insurance Co. Name:		
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address:		
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address:	Zip	
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address: City State Insurance Co. Phone #: (Zip	
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address: City State Insurance Co. Phone #: () Group # (Plan, Local or Policy #):	Zip	
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address: City State Insurance Co. Phone #: () Group # (Plan, Local or Policy #): Insured's Name: Relation:	Zip	
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address: City State Insurance Co. Phone #: () Group # (Plan, Local or Policy #): Insured's Name: Relation: Insured's Birthdate:/ Insured's ID #:	Zip	
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address: City State Insurance Co. Phone #: () Group # (Plan, Local or Policy #): Insured's Name: Relation:	Zip	

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

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