



Welcome

PATIENT INFORMATION

The benefits of a healthy, beautiful smile are immeasurable. Our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. The information on these forms is confidential and will enable us to provide you the very best care possible.

Dr. Mr. Mrs. Ms. Miss

First Name _____ MI _____ Last Name _____

We usually address our patients by their title and surname, unless they request otherwise.

I prefer to be called _____ Birthdate ___/___/____ SS# _____

Home address _____ City _____ Zip _____

E-mail: _____

Phones: Home _____ Work: _____

Cell/Pager: _____

Your occupation _____ Employer _____

Business address _____ City _____ Zip _____

Spouse's name _____ Occupation _____ Work Phone: _____

Other than your spouse, a person to contact in case of emergency _____

Relation to patient _____ Home Ph # _____ Work Ph # _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Our Website Radio/TV Print Media Personal Referral

Personal Referral: If so, whom may we thank? _____

FOR OUR PATIENTS WITH DENTAL INSURANCE ...

Name of policyholder _____ Birthdate ___/___/____ SS# _____

Insurance Co. _____ Group #. _____

Name of employer _____ Relation to patient _____

Are you covered by another insurance plan?

Name of policyholder _____ Birthdate ___/___/____ SS# _____

Insurance Co. _____ Group #. _____

Name of employer _____ Relation to patient _____