



WELCOME TO OUR OFFICE!

Our Purpose Is: We are here to build health-enhancing relationships and friendships with the people in our reach. We each bring a strong personal commitment to our work and by making a significant difference in the lives of others we come to know ourselves better.

PATIENT INFORMATION

Name: Mr. Mrs. _____ Today's Date: ___/___/___

Parent/Guardian Name (If Minor): _____

What would you like us to call you? (*preferred name*): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (*Cell*) _____ (*Other*) _____

Email: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ___/___/___

Whom may we contact in case of emergency:

Name: _____ Relation: _____ Phone: _____

Whom may we thank for referring you: _____

PRIMARY DENTAL INSURANCE

Name of Subscriber: _____ Date of Birth: ___/___/___

Insurance Company: _____ Employer: _____

Group Number: _____ Member Number: _____

SECONDARY DENTAL INSURANCE

Name of Subscriber: _____ Date of Birth: ___/___/___

Insurance Company: _____ Employer: _____

Group Number: _____ Member Number: _____

To the best of my knowledge, the information above is correct. I realize that this office will assist with insurance billing and to the best of their knowledge, however, all charges for services and any finance charge for untimely payments are ultimately my responsibility.

Signature (*parent's if minor*) X: _____ Date: ___/___/___