Personal and Insurance Information

Please fill out the following information. It is very important all information stays up to date. If there are changes in this information or your health or dental histories, please let us know. Thank You.

Your Name: ________________________________ Preferred Name: _________________ Gender: **F M**

Date of Birth: ____________________________ Social Security #: ___________________________________

Address: ____

City: ______________________________ State: _____________ Zip Code: ________________________

E-mail: ____

Home Phone: __________________________________ Cell Phone: ___________________________________

Occupation: _________________________________ Employer: _____________________________________

May we call you at work? ________ Work Phone: ____

Marital Status: ______________________________ Spouse's name: _________________________________

Occupation: _________________________________ Spouse's Employer: _____________________________

Previous Dentist: ____ Phone: ____________________________

Street Address: ____ City, State, Zip: ____________________

May we ask who recommended you to us? ____

BILLING INFORMATION

Responsible Party: _______________________________ Relationship to Patient: ______________________

Street address: ____ Phone: ____________________________

City: _____________________________ State: _____________ Zip Code: ________________________

INSURANCE INFORMATION

Dental Insurance:
Yes No

If you have insurance, please fill out the following information.

Insurance Company: ____

Insurance Company Address: ____

City, State, Zip: ____ Phone: ______________________

Subscriber #: ________________________________ Group #: ____

Employer Providing Coverage: ____

Policy Holder's Name: ____

Policy Holder's Date of Birth: ______________________ Policy Holder's SSN: __________________________