WELCOME

DATE _____

PATIENT INFORMATION

NAME _____

BY WHAT NAME DO YOU LIKE TO BE CALLED? _____ BIRTHDATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE (Home)_____ (Business)_____ (Cell)_____

E-MAIL _____

EMPLOYER _____ OCCUPATION _____

RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THE ACCOUNT?

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY_____ STATE _____ ZIP CODE _____

PHONE (Home)_____ (Business)_____ (Cell)_____

EMPLOYER _____ OCCUPATION _____

DENTAL INSURANCE

POLICYHOLDER NAME _____

ID # _____ **BIRTHDATE** _____

EMPLOYER NAME AND ADDRESS _____

_____

INSURANCE COMPANY NAME AND ADDRESS _____

_____

GROUP NUMBER _____

I authorize release of dental information necessary to process claims and payment of insurance benefits.

(Signature) _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ***REFERRED BY:*** _____

ADVERTISING: Newspaper_____ Radio_____ Phone Directory_____ OTHER: _____

PAYMENT OF FEES FOR DENTAL SERVICES IS REQUESTED AT THE TIME OF TREATMENT

THANK YOU