WELCOME

Thank you for your visit today! We appreciate you trusting us with your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following forms as completely as you can. If you have any questions just ask, we will be glad to help! We look forward to working with you.

Patient Information Date

Name Home phone Cell phone

Address SSN

City State Zip code Age Birth date

Sex male female Single Married Widowed Divorced Occupation

Employed by Work phone E-mail

Whom may we notify in case of emergency?

Whom may we thank for referring you

How may we notify of your appointment? E-mail Phone Cell phone Work phone

Primary insurance

Who is responsible for this account?

Relationship to patient DOB SSN

Address(if different from patient's) Phone

City State Zip code

Employed by Occupation Work phone

Insurance company Group # Number of dependants on this plan

Secondary Insurance

Subscriber name Relationship to patient SSN

Address(if different patient State Zip code Dob

Employed by Work phone Insurance company

Number of other dependents covered by this plan Group #

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for serviced. I agree to be responsible for payment of all services rendered on my behalf.

Signature Date

Please complete the other side!