



WELCOME TO OUR OFFICE

Thank you for choosing our office. In order to provide you with the highest quality and most complete health care, we ask that you please complete the following information. In order to assure you of the confidentiality of your health information, please see our Notice of Privacy Policy.

Circle One:

(Dr., Mr., Mrs., Ms., Miss)

Last Name _____

Address _____

First Name _____

City/ State/Zip _____

Birth Date _____

Home Phone _____

Social Security # _____

Cell Phone _____

Employer _____

Work Phone _____

Address _____

City / State/ Zip _____

Email Address _____

Circle if email is work or personal

Name of Referring Dentist _____

Phone _____

In Case of Emergency _____

Phone _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____

Daytime Phone _____

Address _____

City / State _____

DENTAL INSURANCE INFORMATION

Insurance Company _____

Insured's Employer _____

Company Address _____

Group # _____

City / State/ Zip _____

Policy # _____

Insured's Name _____

Relation: _____

Insured's Birth Date _____

Insured's Social Security # _____

I acknowledge that I have received a copy of this office's Notice of Privacy Policy. _____
Initials

Payment is due in full at the time of treatment unless prior arrangements have been approved. If this office agrees to accept my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

Signature

Date