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Welcome to our office. We appreciate the confidence you place with us to provide dental service. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT'S NAME _____ Date _____

Preferred Name _____ Sex ❑ F ❑ M

❑ Married ❑ Single ❑ Other _____

Birthdate _____

Mailing Address _____

City/State _____ Zip _____

Home Phone _____ Cell _____

Employer _____ Work Phone _____ Ext # _____

❑ Email _____

Soc. Security No. _____

Patient Occupation _____

How can we best reach you? ❑ Cell ❑ Pager ❑ Work ❑ Home

Time of Day _____ ❑ AM ❑ PM

Name of Spouse _____

Birthdate _____

Cell _____

Work Phone _____ Ext # _____

Soc. Security No. _____

Occupation _____

Employer _____

Names of children living at home:

Name	Birthdate

Previous Dentist's Name _____ Telephone # _____

Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE

Employee _____

Employer _____

Insurance Co. _____ Group# _____

Phone No. _____

Insurance ID No. _____

SECONDARY DENTAL INSURANCE

Employee _____

Employer _____

Insurance Co. _____ Group# _____

Phone No. _____

Insurance ID No. _____

Person responsible for payment: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Hm Phone No. _____ Wk Phone No. _____

Relationship to Patient _____

Physician's Name _____ Phone No. _____