To help us meet your entire healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Mr. / Mrs. / Miss Name _____ Date _____

Soc. Sec. # _____ Birth Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Ok to Receive Correspondences via Text: Yes or N0 Cell Phone_____

Ok to Receive Correspondences via E-mail: Yes or N0 E-mail _____

Which phone number is best to contact you in the daytime if we have any questions _____

Previous Dentist _____Medical Physician _____ Phone# _____

Pharmacy_____ Emergency Contact _____ Phone #_____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person for this Account _____Relationship to Patient_____

Address _____ Home Phone _____ Drivers License # _____

Soc. Sec. # _____ Birth Date _____ Employer _____

Work Phone _____ Is This Person Currently a Patient in our Office? Yes _____ No _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birth Date _____ Soc. Sec.# _____ Date Employed _____

Name of Employer _____

Insurance Company _____ Group # _____ Policy/Id# _____

Insurance Comp. Address _____ City _____ State _____ Zip _____

Do You Have Any Additional Insurance? Yes _____ No _____ *(If yes, please complete the following)*

Name of Insured _____ Relationship to patient _____

Birth Date_____ Soc. Sec.# _____ Date Employed _____

Name of Employer _____

Insurance Company _____ Group # _____ Policy/Id# _____

Insurance Comp. Address _____ City _____ State _____ Zip _____