WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date ____________________

Birthdate ____________________

SS#/SIN ____________________ E-Mail ____________________

Name ____________________

Wishes to be called ____________________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address ____________________

City ____________________ State/ Prov. ____________________ Zip/ P.C. ____________________

Employer ____________________ Occupation ____________________

Referred by ____________________

2 Responsible Party

Who is responsible for the account?

Name ____________________

Relationship to patient ____________________

Birthdate ____________________ Driver's License # ____________________

SS#/SIN ____________________ E-Mail ____________________

Address ____________________

City ____________________ State/ Prov. ____________________ Zip/ P.C. ____________________

Employer ____________________

Occupation ____________________

Work Phone ____________________ Ext. # ____________________

Home Phone ____________________ Cell Phone ____________________

3 Telephone

Home Phone ____________________

Work Phone ____________________ Ext. # ____________________

Cell Phone ____________________

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Car

When is the best time to reach you? Time ____________________ Days ____________________

In the event of an emergency, who should we contact?

Name ____________________ Relationship ____________________ Work # ____________________ Home # ____________________

4 Dental Insurance Information

Primary Insurance

Name of Insured ______________________

Relationship to patient ______________________

Insured's birthdate ______________________

SS#/SIN ______________________

Employer ______________________

Date Employed ______________________

Occupation ______________________

Insurance Company ______________________

Group # ______________________

Employee/Cert. # ______________________

Ins. Co. Address ______________________

Deductible ______________________

Amount already used ______________________

Max. annual benefit ______________________

Additional Insurance

Name of Insured ______________________

Relationship to patient ______________________

Insured's birthdate ______________________

SS#/SIN ______________________

Employer ______________________

Date Employed ______________________

Occupation ______________________

Insurance Company ______________________

Group # ______________________

Employee/Cert. # ______________________

Ins. Co. Address ______________________

Deductible ______________________

Amount already used ______________________

Max. annual benefit ______________________