GETTING TO KNOW OUR PATIENT

Welcome to our dental family! We are so happy to be your dentist! Please fill out this form to the best of your ability. This completed form will help us to better serve you. We appreciate your cooperation and help!

Date: _____

PATIENT INFORMATION

Patient Name (First / Middle Initial / Last): _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Home Address: _____ City, State, ZIP _____

Email Address: _____ Marital Status: Single /Married/Divorced/Separated

Driver License #: _____ Issuing State: _____

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Insurance ID #: _____ Social Security Number: _____-_____-_____

Dental Primary Insurance Company: _____ Group: _____

Dental Secondary Insurance Company: _____ Group: _____

RESPONSIBLE PARTY

Patient Name (First / Middle Initial / Last): _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Home Address: _____ City, State, ZIP _____

Insurance ID #: _____ Marital Status: Single /Married/Divorced/Separated

Driver License #: _____ Issuing State: _____ Relationship to Patient: _____

Responsible Party's Employer: _____ Occupation: _____

Business Address: _____ City, State, ZIP _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Choose only one.)

___ Referred by a Friend ___ Referred by Spouse ___ Referred by Employer/Insurance Plan ___ Google

___ Online Reviews ____ Yelp ___ Website ___ Social Media ___ Sign by Building ___ Direct Mailing

___ Newspaper Ad ___ Creative Smiles Employee ___ Dental Specialist ___ Other

_____ _____ _____

Signature Date Relationship to Patient