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