Welcome!

ABOUT YOU

Today's Date:_____/_____/_____
Patient Name:_____
Last First MI

What You Prefer To Be Called:_____
€ Male Female
Birthdate:___/___/___ Age:___ SS#:_____
Mailing Address:_____
City State Zip

Home Phone#: (_____)_____
Work Phone#: (_____)_____
Cell Phone#: (_____)_____
E-Mail Address:_____
Referred By:_____
Employer:_____ How Long?_____
Employer's Address:_____
City State Zip

Occupation:_____
Status: Minor Single Married Divorced Separated Widowed
Spouse's Name:_____
Do you have children? Yes No

INSURANCE INFO

Primary Dental Insurance
Co. Name:_____
Address:_____
City State Zip

Phone#: (_____)_____
Insured's ID#:_____
Group# (Plan, Local, or Policy #):_____
Insured's Name:_____
Relation:_____ Date of Birth:___/___/____
Insured's Employer:_____

Secondary Dental Insurance
Co. Name:_____
Address:_____
City State Zip

Phone#: (_____)_____
Insured's ID#:_____
Group# (Plan, Local, or Policy #):_____
Insured's Name:_____
Relation:_____ Date of Birth:___/___/____
Insured's Employer:_____

ACCOUNT INFO

Person ultimately responsible for account
Name:_____
Relation:_____
Billing Address:_____
City State Zip

SS#:_____
Driver's License #:_____
Work Phone #: (_____)_____
Payment Method: **CASH** **FINANCE**
_____ ___/___
CREDIT CARD - Enter Card # above (if accepted)

_____ initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

IN EVENT OF EMERGENCY

Who do we contact?_____

Relation:_____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (_____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone #: (_____)_____

Kaiser Medical Record#_____