

Welcome

ABOUT YOU

Today's Date: _____ E-mail Address: _____
Name: _____ I prefer to be called: _____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr
Birthdate: ____/____/____ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Home Address: _____
Street City State Zip
Home Phone #: (____) _____ Cell #: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver License #: _____
Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____
Other family members seen by us: _____
Employer: _____ How long there? _____ Occupation: _____
Employer's Address: _____
Street/PO Box City State Zip
Neighbor or Relative not living with you
His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____
Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____
Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____
Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____
Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No
Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____
Insurance Co. Address: _____
Street/PO Box City State Zip
Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ____/____/____ Relation: _____
Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ☐ Yes ☐ No Medical Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No
Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____
Insurance Co. Address: _____
Street/PO Box City State Zip
Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ____/____/____ Relation: _____
Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

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