



# WELCOME

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL#: \_\_\_\_\_

SSN#: \_\_\_\_\_ Sex: Male Female

Marital Status: Married Single Divorced Separated Widow

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Parent/Guardian** (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

## EMERGENCY CONTACT

Person to contact in case of emergency:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Ins: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_

Policy Holder DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

ID# or SSN#: \_\_\_\_\_

Policy / Group #: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Patient relationship to holder: Self Spouse Child Other

Home Phone: \_\_\_\_\_

## REFERRAL SOURCE

Who may we thank for referring you to our practice?

(Circle): Family Friend Doctor Internet Location

Name: \_\_\_\_\_

Advertising Source: \_\_\_\_\_

## APPOINTMENT POLICY:

We make every effort to schedule your appointment to fit your schedule, **so we ask for no less than 24 hours notice to cancel or reschedule an appointment for any reason. A \$35 fee will be assessed.** Your appointment time is yours exclusively, so not showing for your appointment is time wasted. We look forward to the time we set aside for your necessary dental treatment.