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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