Welcome to our office...*To provide you with the best care possible we will need the following information completed. All information is strictly confidential.*

Patient Information
Name_____
Birth Date_____
Address_____

Today's Date: _____
Social Security #_____
Home Phone#_____
City_____ State____ Zip_____

Employer _____
Business Address _____
If Student, Name of School/College_____

Work Phone# _____
Patient Cell# _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Person to Contact in Case of Emergency_____
Phone#_____
Relationship to You_____

Name of Dentist: _____
Primary Care Physician: _____

Person responsible for payment if other than patient: ☐ **Not applicable**
Name_____
Address _____
Relationship to Patient_____
Home Phone#_____ Birthdate_____ Social Security Number_____
Work Phone#_____Employer_____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is required at each appointment. If you use a credit card 3% processing fee will be added.

☐ *Cash* ☐ *Personal Check* ☐ *Visa* ☐ *Master Card* ☐ *Discover* ☐ *American Express* ☐ *Care Credit*

Medical Insurance: ☐ **None**

Name of Insurance_____
Address_____
_____
Phone Number_____
Identification Number_____
Group Number_____

Subscriber Name_____
Social Security Number_____
Birth Date_____
Employer_____
Relationship to Patient_____
If retired, retirement date_____

Dental Insurance: ☐ **None**

Name of Insurance_____
Address_____
_____
Phone Number_____
Identification Number_____
Group Number_____
How much is your yearly deductible? _____

Subscriber Name_____
Social Security Number_____
Birth Date_____
Employer_____
Relationship to Patient_____
Maximum Annual Benefit_____

Please present your insurance cards, so we may maintain a copy in your records. If you have additional insurance information, please discuss with office staff.