Welcome to our Practice!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: ____/____/______
Patient name: ____ Preferred name: _________________
Birth date: ___/___/_____ Social Security Number: _______-_______-_______
Male ☐ Female ☐
Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered ☐ for ___ years.
Are you a full-time student? Yes ☐ No ☐ Where? ____
What are your hobbies, interests or passions? ____
____
Who may we thank for referring you? ____

Contact Information

Mailing address: ______________________________________ Apt. # _____
City: ______________________________________
State: ____________ Zip ____________
Home phone ( ) __________ Work ( ) ___________ Cell ( ) ____________
E-mail address: _________________________@________________________
How would you like us to contact you or leave a message? (check all that apply)
Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail ☐
Is it okay for us to send you a postcard reminder for appointments? Yes ☐ No ☐

Insurance Information - Primary

Name of insured: ____________________________ Date of Birth: ____/____/_____
Insured's Employer: __________________________ Work Phone: (____) _________
Insured's Social Security #: _______-_____-_______
Insurance Company: ____
Group #: __________________ Insurance ID #: ____________________
Insurance Phone # (_____) _____________
Insurance Address: ____
Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance Information - Secondary

Name of insured: ____________________________ Date of Birth: ____/____/_____
Insured's Employer: __________________________ Work Phone: (____) _________
Insured's Social Security #: _______-_____-_______
Insurance Company: ____
Group #: __________________ Insurance ID #: ____________________
Insurance Phone # (_____) _____________
Insurance Address: ____
Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Office Policies

- I understand that my appointment times are reserved exclusively for me and a charge of $60 per hour may be charged when I fail to appear or when I cancel or reschedule without giving the office 48 hours notice.
- I understand that I am responsible for all the cost of dental treatment.
- I understand that as a courtesy to me this office will file insurance claims, but that determining eligibility, coverage maximums and contract year is solely my responsibility.
- I authorize payment benefits to be sent to the dentist.
- I authorize the release of information related to my dental treatment to my insurance company.
- I will inform the office of any insurance coverage changes prior to my appointment.
- I understand that I may incur a 1% finance charge if my balance goes beyond 90 days.

Please sign here: ____