



We are pleased to welcome you to our practice. Please take a few minutes to fill out the form. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

<b>Patient Information</b>	
First Name: _____ Last Name: _____ Middle Initial: _____	
Address: _____ Preferred Name: _____	
City: _____ State: _____ Zip: _____	
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____	
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed	
Sex: <input type="radio"/> Male <input type="radio"/> Female	
Birth Date: _____ Age: _____ Soc. Sec: _____	
Email: _____ <input type="radio"/> I would like to receive correspondence via email	
Employer: _____ Occupation: _____	
Spouse: _____	
Children's Names: _____	
Is there anyone we may thank for referring you to our offices? _____	

<b>Primary Dental Insurance Information</b>	
Name of Insured: _____ Relationship to Patient: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	
Insured Soc. Sec. _____ Insured Birth Date: _____	
Employer: _____	
Ins. Company: _____ Ins. Phone#: _____	
Ins. Co. Address: _____	
Group #: _____ ID #: _____	

<b>Payment Options</b>
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To help keep the cost of dentistry down and to continue to provide quality care to our valued patients, we now expect payment in full on your first visit. Subsequent visit balances not covered by your insurance can be paid using the following options:

Please  below the option(s) most convenient for you to pay on your account balance.

- Cash
- Check
- Visa, MC, Amex, or Discover
- Easy monthly payment program (see insurance coordinator for application)

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date