



We warmly welcome you to our office. Please take a few moments to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____ I prefer to be called: _____

Male Female Birth date: _____ Social Security Number: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail Address: _____

Occupation: _____ Employer: _____

Employer Address: _____

Whom may we thank for referring you? _____ Other family members seen by us? _____

How do you prefer to confirm your appointment? _____ Where and when are the best times to reach you? _____

Previous / Present Dentist: _____ Phone Number: _____

Last Visit Date _____

Primary Dental Insurance

Insurance Co. Name: _____ Insured's Name: _____

Insurance Co. Address: _____ Relation: _____

Insurance Co. Phone #: _____ Insured's Birth Date: _____

Group # (Plan, Local or Policy#): _____ Insured's S.S. # _____

In the events of an emergency, please indicate someone who lives near you that we should contact:

Name: _____ Relation: _____

Work Phone: _____ Other Phone: _____

A note for our patients with dental insurance:

We will assist you in anyway possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier if you desire. We will do our best to make as close of a calculation as possible of what your insurance plan will cover, however regardless of what your insurance plan pays for you, you are responsible for all fees.

Patient Initial _____

Appointment Cancellation Policy:

Please help us deliver the best quality dental care by keeping scheduled visits. If unable to keep your appointment please give at least 48 hours. We reserve the right to charge \$50.00 per hour for appointments canceled with less than adequate notice.

Patient Initial _____

