WELCOME

DATE: _____

Our goal is to help you achieve and maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team of dental professionals. We will continue to warrant that trust as we serve your dental needs.

Personal Profile

First Name _____ Middle Initial _____ Last Name _____
I like to be called _____ ❑ Male ❑ Female
Date of Birth / / Age:_____ Driver's License # _____
Home Address _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone: (___) _____ Work Phone: (___) _____ Ext _____
Pager _____ E-mail _____ Cell Phone _____ Fax Phone _____
What number would you like us to call you on regarding your appointments? _____
Name of Employer: _____ Occupation: _____
Address _____ City _____ State _____ Zip _____

Who referred you to our practice?

Previous dentist's name: _____
Last seen by your previous dentist? _____ Treatment rendered: _____
Would you like us to contact your previous dentist for applicable records? ❑ No ❑ Yes

Account Information

Responsible party's name: _____
Address _____ City _____ State _____ Zip _____
Home Phone: (___) _____ Work Phone: (___) _____ Ext _____
[redacted] Date of Birth / / [redacted]

Insurance Information - Primary (We Do Not Accept Insurance as Payment)

Insurance Company (Dental Only)
Name: _____
Address _____ City _____ State _____ Zip _____
Insured's First Name _____ Middle Initial _____ Last Name _____
Social Security # _____ - _____ - _____ Or ID # _____ Date of Birth / /

Who should we contact in the unlikely event of an emergency:

Name: _____ Relationship to patient _____
Home Phone: (___) _____ Work Phone: (___) _____ Ext _____
E-mail _____ Cell Phone (optional) _____
Please state your chief dental complaint _____
_____
What would you like to achieve with dental care _____
_____

Signature: _____

PATIENT REGISTRATION INFORMATION