Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information

Name_____ Birthdate_____ Home Phone_____ Mobile Phone_____

Address_____ City_____ State_____ Zip_____

Circle Appropriate Category: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College_____ City_____ State_____ Full/Part Time

Patient of Parent/Guardian's Employer_____ Work Phone_____

Employer's Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____

Person to contact in case of emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone _____

Email _____ Mobile Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____

Insurance Information

Name of Insured_____ Relationship to Patient _____

Birthdate _____ Employer_____ Union/Local # _____ Work Phone_____

Address of Employer _____ City _____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID #_____

Ins. Co. Address_____ City _____ State_____ Zip_____

Additional Insurance Information (Second Insurance)

Name of Insured_____ Relationship to Patient _____

Birthdate _____ Employer _____ Union/Local # _____ Work Phone_____

Address of Employer _____City _____State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID #_____

Ins. Co. Address_____ City _____State_____ Zip_____