WELCOME

Date _____

Patient's Name _____
Last First Initial

If Child: Parent's name _____

Residence –

_____
Street City State Zip

Telephone res. _____ Cell phone _____

Email _____

Patient/Parent employed by _____

Business address _____ Business phone _____

Present position _____ How long held _____

Spouse name _____

Spouse employed by _____

Present position _____ How long held _____

Who is responsible for this account _____

Drivers license no. _____

Purpose of call _____

Other family members in this practice _____

Whom may we thank for this referral? _____

Patient/parent social security number _____ Patient date of birth _____

Spouse social security number _____

Someone to notify in case of emergency not living with you _____

Telephone number _____

DENTAL INSURANCE – 1ST COVERAGE

Employee name _____ Date of Birth _____

Relationship to patient _____

Employer name _____ Years _____

Name of Insurance Co. _____

Address _____

Telephone _____ Program or policy no. _____

Union local or group _____

DENTAL INSURANCE – 2nd COVERAGE

Employee name _____ Date of Birth _____

Relationship to patient _____

Employer name _____ Years _____

Name of Insurance Co. _____

Address _____

Telephone _____ Program or policy no. _____

Union local or group _____