Thank you for selecting us for your dental healthcare! To help us meet your needs, please fill out this information form. If you have any questions or need assistance, please ask us and we'll be happy to help.

Patient Information

First Name _____ **Middle Initial** _____ **Last Name** _____

By what name do you prefer us to call you? _____

Street Address _____

Mailing Address (if different) _____

Town _____ **State** _____ **Zip**_____

Home Phone _(_____)_____ **Work Phone** _(_____)_____

Date of Birth _____ **Social Security Number** _____

Check appropriate box: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Student**

(If you are a student, name of school and town _____ **Full time / Part time**

E-mail address _____ **Cell Phone** (_____)_____

Emergency Contact Name _____ **Phone** (_____)_____

Name of Employer (or Spouse's Employer) _____

Employer Address _____

Where may we call you for appointment confirmation? __ **Home** __ **Office** __ **Cell**

May we leave messages on your answering machine or voice mail? __ **Yes** __ **No**

How did you hear about our practice? _____

Dental Insurance Information

Policy Holder_____ Relationship _____

Date of Birth _____ Social Security Number _____

Is this person currently a patient in this office? ☐ Yes ☐ No

Name of Employer _____

Insurance Company _____ Group ID Number _____

Insurance Company Address _____

Phone Number _____

Maximum annual benefit _____ How much have you used this year? _____

How much is your deductible? _____

Do you have any other dental insurance? ☐ **No** ☐ **Yes** **If yes, please complete the following:**

Policy Holder_____ Relationship _____

Date of Birth _____ Social Security Number _____

Name of Employer _____

Insurance Company _____ Group ID Number _____

Insurance Company Address _____

Phone Number _____

Maximum annual benefit _____ How much have you used this year? _____

How much is your deductible? _____

DRIVER'S LICENSE NUMBER _____ **SIGNATURE** _____