
# Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us and we will be happy to help.

**Patient Information** (Confidential)

Name_____ Date_____ SS# _____

Birthdate_____ Home#_____ Cell# _____

Email_____ Wk# _____

Address _____ City _____ State _____ Zip_____

When confirming appts how do you prefer to be contacted? ___Phone ____Email ___Text Msg

Spouse or Parent's Name _____ Phone#_____

**How did you hear about our office?** (Check all that apply)

___Google ___Website ___Drive By ___Mailer ___ Other

___ Patient _____

Person to Contact in Case of Emergency_____ Phone # _____

**Responsible Party**

Name of Person Responsible for this Account _____Relationship _____

Contact #_____ Birthdate _____ Employer _____

**Insurance Information**

Name of Insured _____Relationship to Patient_____

Birthdate _____ Social Sec# _____ Work#_____

Name of Employer _____ Insurance Co. _____

Group# _____ Policy/ID#_____ Customer Service # _____

Ins Co. Address _____ City _____ St_____ Zip _____

Authorization and Release I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

**I agree to be responsible for payment of all service rendered on my behalf of myself and any dependents.**

**Signature of Patient** (Parent if patient is a Minor) _____