Welcome To Our Practice!

The benefits of a happy, healthy smile are immeasurable!
A beautiful smile is a wonderful asset.
Please fill out this form completely.
The better we communicate, the better we can care for you.

About You

Today's Date: ____________

Name: (LAST, FIRST, MI) ____________ I prefer to be called: ____________

Birthdate: ____/____/____ Age: ______ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: ____________ STREET APT/CONDO # CITY STATE ZIP

E-Mail Address: ____________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________ Ext: ______

Employer: ____________ Employer's Address: ____________

Occupation: ____________ How long there? ______

Where & when are best times to reach you? ____________

Whom may we Thank for referring you? ____________

Other family members seen by us: ____________

General Dentist: ____________ **Last Visit Date:** ____________

Spouse Information

His/Her Name: ____________ Employer: ____________

Work Phone: ____________ Ext: ______ SS #: ____________ Birthdate: ____/____/____

Person Responsible for Account:

Work Phone: ____________ Ext: ______ Home Phone: ____________ Cell Phone: ____________

Billing Address: ____________ Relation: ____________

SS #: ____________ Employer: ____________

Orthodontic Insurance

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________ Ins. Co. Phone: ____________

Insurance Co. Address: ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ____/____/____ Insured's SS #: ____________ Insured's Employer: ____________

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________ Ins. Co. Phone: ____________

Insurance Co. Address: ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ____/____/____ Insured's SS #: ____________ Insured's Employer: ____________

In the event of an emergency, is there someone who lives near you that we could contact?

His/Her Name: ____________ **Relation:** ____________

Work Phone: ____________ **Home Phone:** ____________

Medical History

Do you have a personal physician? ☐ Yes ☐ No Physician's Name: ____________

Phone: ____________ Date of Last Visit: ____________

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