

FOR ADULTS: WELCOME TO OUR PRACTICE

1.) ABOUT YOU			
Today's date: _____		DOB: _____	
Name: _____		AGE: _____	
Last _____	First _____	Mi _____	(Mr. Mrs. Ms.) _____
I preferred to be called: _____			
Home #: _____			
Work #: _____			
SS #: _____			
DL #: _____			
Home Address:			
			Apt# _____
City _____	State _____	Zip _____	

4.) RESPONSIBLE PARTY INFO:			
Name: _____			
Billing address: _____			
City _____	State _____	Zip _____	
WK#: _____	Ext. _____	HM#: _____	
Cell #: _____			
Email: _____			
Employer: _____			
DL#: _____			
SS#: _____			
Emergency Contact:			
Name: _____		Relation: _____	
WK#: _____	Ext. _____	HM#: _____	

2.) ABOUT YOUR EMPLOYER:
Name: _____
Address: _____
How long have you worked there? _____
Occupation: _____
When & Where are the best times to reach you? _____
Other family members seen by us: _____
Who may we THANK for referring you? _____

5.) PRIMARY DENTAL INSURANCE:
Ins. Name: _____
Ins. Address: _____
Insurance Co. Phone #: _____
Group/Policy #: _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
Orthodontic Coverage: YES NO
SECONDARY DENTAL INSURANCE
Ins. Name: _____
Ins. Address: _____
Insurance Co. Phone #: _____
Group/Policy #: _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
Orthodontic Coverage: YES NO

3.) SPOUSE INFORMATION:
Name: _____
Employer: _____
WK#: _____
DL#: _____
SS#: _____
DOB: _____
DENTAL INFORMATION:
Previous/Present Dentist: _____
Street: _____
Phone: _____ Last visit: _____