

PATIENT INFORMATION FORM

Welcome!

For us to better serve you, please fill out these forms completely.

Mission Statement:

To improve the quality of life for every individual who visits our office by protecting, promoting and educating them on their oral health. To provide high-quality dentistry, with an emphasis on prevention, to individuals in and around our community within a comfortable and friendly environment that is reflective of our commitment to personal care.

About You

Name _____
Preferred Name _____ Male Female
 Single Married Divorced Widowed Separated
Birthdate ___/___/___ Age ___ SS# _____
Address _____
City _____ State _____ Zip _____
Email _____
Home # _____ Work # _____
Cell # _____ Fax # _____
Whom may we thank for referring you?

Other family members seen by us _____
Employer _____

Spouse Info

Name _____
Home # _____ Work # _____
Cell # _____ Birthdate ___/___/___

Insurance

Provider Name _____
Provider Phone # _____
Group # _____
Insured's Name _____ Relation _____
Insured's Birthdate ___/___/___ Insured's SS# _____
Insured's Employer _____
Insured's Phone # _____

Account Information
PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
Home # _____ Work # _____
Cell # _____ Birthdate ___/___/___
Email _____
Billing Address _____
City _____ State _____ Zip _____

Secondary Insurance

Provider Name _____
Provider Phone # _____
Group # _____
Insured's Name _____ Relation _____
Insured's Birthdate ___/___/___ Insured's SS# _____
Insured's Employer _____
Insured's Phone # _____