

Our goal is to help you achieve and maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team of dental professionals. We will continue to warrant that trust as we serve your dental needs.

Personal Profile

Date _____ / _____ / _____

First Name _____ Middle Initial ____ Last Name _____

I like to be called _____ Male Female

Date of Birth ____ / ____ / ____ Age: ____ Social Security # _____ - _____ - _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext _____

E-mail _____ Cell Phone _____ Fax Phone _____

What number would you like us to call you on regarding your appointments? _____

Name of Employer: _____ Occupation: _____

Address _____ City _____ State _____ Zip _____

Who may we thank for referring you to our practice?

Previous dentists name: _____ Phone: (____) _____

Last seen by your previous dentist? _____ Treatment rendered: _____

Would you like us to contact your previous dentist for applicable records? No Yes

Account Information

Responsible party's name: _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext, _____

Social Security # _____ - _____ - _____ Date of Birth ____ / ____ / ____ Driver's License # _____

Insurance Information - Primary - DENTAL ONLY

Insurance Company Name: _____

Address _____ City _____ State _____ Zip _____

Insured's First name _____ Middle Initial ____ Last Name _____

Social Security # _____ - _____ - _____, Date of Birth, ____ / ____ / ____ GRP/ID# _____

Insurance information - Secondary

Insurance Company Name: _____

Address _____ City _____ State _____ Zip _____

Insured's First name _____ Middle Initial ____ Last Name _____

Social Security # _____ - _____ - _____, Date of Birth, ____ / ____ / ____ Driver's License # _____

Who should we contact in the unlikely event of an emergency:

Name: _____ Relationship to patient _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext _____

E-mail: _____

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