



Where the Patient is Our Primary Concern

PATIENT INFORMATION

DATE _____

PATIENT NAME MR. ___ MRS. ___ MS. ___ MISS ___ DR. ___ _____

HOME ADDRESS _____
Street city zip

HOME PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____ PAGER: (____) _____ - _____

BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS (S___) (M___) (D___) (W___)

SS# _____ - _____ - _____ DRIVER'S LICENSE # _____ - _____ - _____

EMPLOYER NAME / ADDRESS _____

WORK PHONE: (____) _____ - _____ x _____ May we call you at work? YES _____ NO _____

E-MAIL ADDRESS _____

INSURANCE INFORMATION

DENTAL INSURANCE? YES ___ NO ___ Insurance Company? _____

Policy Holders Name _____ D.O.B. _____

Employer _____ Address _____
Street city zip

S.S.# of policy holder _____ GROUP # _____

****YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR EMPLOYER. IT IS IMPOSSIBLE FOR US TO KNOW EVERY PATIENTS POLICY AS ALL OF THEM DIFFER. ANY CLAIM NOT COVERED FOR ANY REASON IS YOUR RESPONSIBILITY. (IE: MISSING TOOTH CLAUSE, WAITING PERIOD, NON COVERED PROCEDURE, IMPLANTS)**

Who may we thank for referring you? _____

REASON FOR CONSULTATION _____

SIGNATURE OF RESPONSIBLE PARTY

DATE