



We are pleased to welcome you to our practice. Please take a few minutes to fill out the form. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

<b>Patient Information</b>		
First Name: _____	Last Name: _____	Middle Initial: _____
Address: _____ Preferred Name: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____	Work Phone: _____	Ext: _____ Cellular: _____
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed		
Sex: <input type="radio"/> Male <input type="radio"/> Female		
Birth Date: _____	Age: _____	Soc. Sec: _____
Email: _____ <input type="radio"/> I would like to receive correspondence via email		
Employer: _____		Occupation: _____
Spouse: _____		
Children's Names: _____		
Is there anyone we may thank for referring you to our offices? _____		

<b>Primary Dental Insurance Information</b>	
Name of Insured: _____	Relationship to Patient: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other
Insured Soc. Sec. _____	Insured Birth Date: _____
Employer: _____	
Ins. Company: _____	Ins. Phone#: _____
Ins. Co. Address: _____	
Group #: _____	ID #: _____

<b>Payment Options</b>
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To help keep the cost of dentistry down and to continue to provide quality care to our valued patients, we now expect payment in full on your first visit. Subsequent visit balances not covered by your insurance can be paid using the following options:

Please  below the option(s) most convenient for you to pay on your account balance.

- Cash
- Check
- Visa, MC, Amex, or Discover
- Easy monthly payment program (see insurance coordinator for application)

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date