



# THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

## PATIENT INFORMATION (CONFIDENTIAL)

Patient Number \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

SS#/SIN \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Separated  Divorced  Widowed

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## RESPONSIBLE PARTY

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

Do You Have Any Additional Insurance?  Yes  No If Yes, Complete the Following

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

Over Please