PATIENT INFORMATION

Name: _____ SS#_____

What name would you like to be called in our office? _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone_____

What E-Mail Address could we use? _____

Employer: _____ Address: _____ Occupation: _____

What is the best way to contact you regarding your appointments? Circle **(text)** **(e-mail)** **(phone)**

Birthdate: _____ Sex: _____ Marital Status: _____ Spouse's Name: _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

(For Dependents and Minors)

Name: _____ SS#_____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____
Name

_____
Street City State Zip

Employee: _____ Relationship to Patient: _____

Employee's SS # _____ Employee's Birthdate: _____ Group Policy #_____

Employer: _____
Name Street City State Zip Phone

Do you have Secondary Insurance Coverage? (YES) (NO) Please circle one

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Address: _____ Phone: _____

Broken Appointment Policy: *Because we reserve a treatment room and the doctor's time exclusively for you when you schedule an appointment, any change in that appointment affects many people. As such, we strongly discourage and reserve the right to charge for a missed appointment. *If you must change your appointment time, we ask for a 48-hour notice (2 business days) so that we can appoint another patient in need. Messages left on the office voicemail are not acceptable, you must speak with a team member.*

Signature: _____ Date: _____