

FOR ADULTS: WELCOME TO OUR PRACTICE

1) ABOUT YOU

Today's date: _____ DOB: _____

Name: _____ Age: _____

Last _____ First _____ Mi _____ (Mr. Mrs. Ms.)

I prefer to be called: _____

Home #: _____

Work #: _____

SS # _____

DL # _____

Home Address:

Apt.# _____

City _____ State _____ Zip _____

When & Where are the best times to reach you? _____

Other family members seen by us: _____

Who may we THANK for referring you? _____

2) ABOUT YOUR EMPLOYER

Name: _____

Address: _____

How long have you worked there? _____

Occupation: _____

3) SPOUSE INFORMATION

Name: _____

Employer: _____

WK# _____

DL#: _____

SS#: _____

DOB: _____

DENTAL INFORMATION

Previous/Present Dentist: _____

Street: _____

Phone: _____ Last Visit: _____

4) RESPONSIBLE PARTY INFO

Name: _____

Billing Address: _____

City _____ State _____ Zip _____

WK# _____ Ext. _____ HM#: _____

Cell #: _____

Email: _____

Employer: _____

DL#: _____

SS#: _____

Emergency Contact

Name: _____ Relation: _____

WK#: _____ Ext. _____ HM#: _____

5) PRIMARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

Ins. Co. Phone #: _____

Group/Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

Ins. Co. Phone #: _____

Group/Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: YES NO

