



The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

About You

Date \_\_\_\_\_

Name \_\_\_\_\_ Last First Middle

I prefer to be called \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ City State Zip Code Email Address

\_\_\_\_\_ Single Married Divorced Widowed Separated

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation \_\_\_\_\_

When/where/best time to reach you? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Last visit date \_\_\_\_\_

Spouse Information

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

Employer \_\_\_\_\_ City \_\_\_\_\_

Work phone \_\_\_\_\_ Ext. \_\_\_\_\_ SS# \_\_\_\_\_

Nearest Relative Not Living With You: Name \_\_\_\_\_ Phone \_\_\_\_\_

Dental Insurance Information

Primary Insurance Company Name \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Group # \_\_\_\_\_ Phone # \_\_\_\_\_

ID# \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Dental Insurance \_\_\_\_\_

Who is responsible for the balance due on this account (in addition to insurance payment)?

\_\_\_\_\_ Myself \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_