CHART # _____

Welcome!

Thank you for your confidence in selecting our dental team! We want you know we take your entire health seriously and will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs and expectations of our team, please complete this form using ink. If you have questions, or need assistance completing this form, please let us know. We will be happy to help.

CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

□ Female □ Male □ Married □ Single □ Child □ Other: _____

Social Security #: _____ - _____ -_____ Date of Birth: _____ / _____ / _____

Home Address: _____ Home Phone: (____) _____
Street Apt # Work Phone: (____) _____
Ext: _____
_____
City State Zip Code Cell Phone: (____) _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for this Account: _____
Last First MI

Relationship to Patient: □ Mother □ Father □ Grandparent □ Sibling
□ Legal Guardian □ Other: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Driver's License # _____

Home Address: _____ Home Phone: (____) _____
Street Apt # Work Phone: (____) _____
Ext: _____
_____
City State Zip Code Cell Phone: (____) _____

Employer: _____

INSURANCE COMPANY INFORMATION - PRIMARY COVERAGE

Name of Insured Party: _____ Date of Birth: _____ / _____ / _____
Last First MI
Social Security #: _____ - _____ - _____ Relationship to Patient: □ Mother □ Father □ Legal Guardian

Employer: _____ Military Rank (if applicable): _____
Address/Unit: _____ Work Phone: (____) _____
Street Apt #
Ext: _____
_____
City State Zip Code
Insurance Company: _____ Group # _____
Street Suite #
_____ Effective Date: ____/____/____
City State Zip Code