Name____
Home#____
(Last) (First) (Middle)

Work#________________________________ Other# ________________________________
Email Address___________________________________

Soc. Sec #____ Gender Male /Female Birth
Date_____________________________

Address____
____

City____ State__________________________
Zip_________________________________

Single Married Spouse's Name
____

Person to call in case of an emergency____
Phone_______________________________

Referred By:____

Insurance Information

Primary Dental Insurance ____
Employer____

Group #____Name of Policyholder
____

Policyholders date of Birth ____Policyholders Soc. Sec#
____

Secondary Dental Insurance ____ Employer
____

Group#____Name of Policyholder
____

Policyholders Date of Birth____________________________ Policyholders Soc. Sec#
____

I am financially responsible for my own account. I understand that the information that I have given here today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it's my responsibility to inform this office of any changes in my medical status.
Payment is due in full at time of treatment unless prior arrangements have been made.

Sign Here:
____**Date:**_______________________________________