

# Welcome

We are please to welcome you to our practice.

Please take a few minutes to fill out this form as completely as you can.

If you have questions we'll be glad to help you. Thank you for taking the time to complete this questionnaire.

## Patient Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Sex M F Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Married Widowed Single  
Separated Divorced

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Phone ( ) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Yellow Pages \_\_\_ Other \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone( ) \_\_\_\_\_

Person responsible for this account \_\_\_\_\_

## Primary Dental Insurance (If Any)

Policy Holder \_\_\_\_\_ Soc. Sec./I.D. # \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Policy Holder Birth Date \_\_\_\_\_

Policy Holder Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Company Phone # ( ) \_\_\_\_\_ Mailing Address \_\_\_\_\_

## Additional Dental Insurance (If Any)

Policy Holder \_\_\_\_\_ Soc. Sec./I.D.# \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Policy Holder Birth Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Phone # ( ) \_\_\_\_\_ Mailing Address \_\_\_\_\_

Policy Holder Relationship to Patient \_\_\_\_\_