WELCOME

Thank you for selecting us for your dental needs.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential) *TODAY'S DATE*_____

Name_____ **Birth Date**_____

Soc. Sec. # _____ **Home Ph #**_____ **Cell #** _____

Address_____ **City**_____ **State**_____ **Zip Code**_____

Male_____ **Female** _____ ☐**Minor** ☐**Married** ☐**Single** ☐**Separated** ☐**Divorced** ☐**Widowed**

Employer _____ **Wk #** _____

May we contact you at work? Yes ☐ No ☐ **E-mail address** _____

Person to Contact in Case of Emergency _____ **Ph #** _____

Whom May we Thank for Referring You? _____

Responsible Party – Insurance Information

Name of Insured Person _____ **Relationship to patient** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Soc. Sec. # _____ **Birth Date** _____ **Home Ph #** _____ **Cell #**_____

Employer _____ **Wk #** _____

Insurance Company _____ **Ph #** _____ **Group #** _____

Do you have any other Dental Insurance? Yes ☐ No ☐

Name:_____ **Phone number:** _____

If your insurance does not pay within 90 days of filing you will be responsible for the total bill. We will provide you with a dental claim form in order for you to file and get reimbursed by your insurance company.

Please Initial _____

We use *MERCURY FREE FILLINGS* in this office. Most insurance companies only pay 80% of mercury fillings on posterior teeth. The patient is responsible for the difference in cost.

Please Initial _____

If you make an appointment with us and fail to keep it without calling us to cancel at least 24 hours in advance, (we understand emergencies do happen) there will be a $25.00 charge per ½ hour time allotted, payable before you will be seen again. Your insurance will not pay for this. This applies to all patients.

Please Initial _____