

Our goal is to help you achieve and maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team of dental professionals. We will continue to warrant that trust as we serve your dental needs.

Personal Profile

Date ____ / ____ / ____
 First Name _____ Middle Initial ____ Last Name _____
 I like to be called _____ Male Female
 Date of Birth ____ / ____ / ____ Age: ____ Social Security # ____ - ____ - ____ Driver's License # _____
 Address _____ City _____ State ____ Zip _____
 Home Phone: (____) _____ Work Phone: (____) _____ Ext _____
 Pager _____ E-mail _____ Cell Phone _____ Fax Phone _____
 What number would you like us to call you on regarding your appointments? _____
 Name of Employer: _____ Occupation: _____
 Address _____ City _____ State ____ Zip _____

Who may we thank for referring you to our practice?

Previous dentists name: _____ Phone: (____) _____
 Last seen by your previous dentist? _____ Treatment rendered: _____
 Would you like us to contact your previous dentist for applicable records? No Yes

Account information

Responsible party's name: _____
 Address _____ City _____ State ____ Zip _____
 Home Phone: (____) _____ Work Phone: (____) _____ Ext _____
 Social Security # ____ - ____ - ____ Date of Birth ____ / ____ / ____ Driver's License # _____

Insurance information - Primary

Insurance Company
 Name: _____
 Address _____ City _____ State ____ Zip _____
 Insured's First name _____ Middle Initial ____ Last Name _____
 Social Security # ____ - ____ - ____ Date of Birth ____ / ____ / ____ Driver's License # _____

Insurance information - Secondary

Insurance Company
 Name: _____
 Address _____ City _____ State ____ Zip _____
 Insured's First name _____ Middle Initial ____ Last Name _____
 Social Security # ____ - ____ - ____ Date of Birth ____ / ____ / ____ Driver's License # _____

Who should we contact in the unlikely event of an emergency:

Name: _____ Relationship to patient _____
 Home Phone: (____) _____ Work Phone: (____) _____ Ext _____
 E-mail: _____ Cell phone (optional) _____