

# Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

## 1. Patient Information

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

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Driver's License # \_\_\_\_\_  
M \_\_\_ F \_\_\_ Check Appropriate Boxes - Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_  
If college student, FT/PT, Name of school \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Nearest relative not living with you \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Who can we thank for referring you? \_\_\_\_\_  
Name & Address of previous Dentist \_\_\_\_\_

## 2. Responsible Party (if different than above)

Guarantor Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Fax # \_\_\_\_\_ E-mail \_\_\_\_\_  
Soc. Sec # \_\_\_\_\_ Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Spouse Name \_\_\_\_\_  
Spouse Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Spouse Soc Sec # \_\_\_\_\_ Spouse birthdate \_\_\_\_\_

## 3. Dental Insurance Information

Primary Insured

Secondary Insured

Name of Insured _____	Name of Insured _____
Relationship to patient _____	Relationship to patient _____
Insured's Birthdate _____	Insured's Birthdate _____
Policy ID# _____	Policy ID# _____
Employer _____	Employer _____
Address _____	Address _____
Insurance Co. _____	Insurance Co. _____
Ins Co Address _____	Ins Co Address _____
Group # _____	Group # _____

Signature \_\_\_\_\_

## 4. Financial Arrangements

For your convenience, we offer the following methods of payment. **Payment for the patient portion is requested in full at each appointment. Financial arrangements must be made prior to services rendered.** We reserve the right to request a credit report in order to extend financial arrangements. Payments may be made by the following methods: Please check the options you prefer.

Cash \_\_\_ Personal Check \_\_\_ Credit Card \_\_\_ Electronic Pay \_\_\_ (request form) Care Credit \_\_\_

You may sign an authorization for us to automatically bill your credit card for balance after insurance pays. Just fill out the following:

VISA \_\_\_\_\_ Mastercard \_\_\_\_\_ Discover \_\_\_\_\_ American Express \_\_\_\_\_ CitiHealthCard \_\_\_\_\_  
Card# \_\_\_\_\_ Exp Date \_\_\_\_\_  
CCV Code \_\_\_\_\_ Signature \_\_\_\_\_