

# WELCOME

## PATIENT INFORMATION (Confidential)

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
(First) (Middle) (Last)

Birth Date: \_\_\_\_\_ Sex: M or F Marital Status: M S D W  
(Please circle) (Please circle)

SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ I would like to receive text messages. Y or N

E-Mail: \_\_\_\_\_ I would like to receive e-mails. Y or N

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

### Dental Insurance Information: -----

Name of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Policy Holder)

SSN: \_\_\_\_\_ Member I.D. : \_\_\_\_\_ Group#: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Comp.: \_\_\_\_\_

### Responsible Party: (Please fill out if different than above) -----

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Driver's L.#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

### Emergency Contact: -----

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes.

**DISCLAIMERS: INSURANCE IS ONLY ESTIMATION. PATIENT IS RESPONSIBLE FOR ALL TREATMENT NOT COVERED BY INSURANCE. PAST DUE ACCOUNTS THAT ARE TURNED OVER TO A COLLECTION AGENCY ARE SUBJECT TO ADDITIONAL FEES – SUCH AS, BUT NOT LIMITED TO: COLLECTION FEES, SERVICES FEES, ATTORNEY FEES, INVESTIGATION FEES, ETC.**

Signature of Patient,  
Parent, or Guardian: \_\_\_\_\_ Date \_\_\_\_\_