



Patient Information (Confidential)

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

NAME: _____ PREFERRED NAME: _____

EMAIL: _____ DOB: / / AGE: _____

MARITAL STATUS: S / M / D / W SEX: MALE / FEMALE SOCIAL SECURITY #: - -

HOME ADDRESS: _____ City / State: _____ Zip: _____

PHONE (HOME): _____ (WORK): _____ CELL: _____

EMPLOYER'S NAME OR SCHOOL NAME: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY CONTACT INFORMATION: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SSN#: - - DOB: / / GROUP #: _____ SUBSCRIBER ID#: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SSN#: - - DOB: / / GROUP #: _____ SUBSCRIBER ID#: _____

EMPLOYER NAME: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

Have you ever experienced Sedation dentistry? Yes No

Would you like to learn more about it? Yes No

Would you like your teeth to be whiter? Yes No

Have you ever thought about straightening your teeth? Yes

RESPONSIBLE PARTY

Signature of Patient/Guardian

Date



Go Wireless, Go Invisalign!

