



WELCOME

CONFIDENTIAL

ABOUT YOU

Today's Date: _____ E-mail address: _____

Name: _____ I prefer to be called: _____ male female

Last First MI Mr. Mrs. Ms. Dr.

Birthdate _____ Age _____ Social Security # _____ Single Married Widowed Divorced Separated

Home Address: _____

Street City State Zip

Home Phone # (____) _____ Pager/Car # (____) _____ Work Phone # (____) _____ Ext. _____

Where & when are the best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____

Street/PO Box City State Zip

Emergency Contact

Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____

Street City State Zip

Person responsible for Account if other than yourself

Name _____ Relation _____ Work Phone # (____) _____ Home Phone (____) _____

Employer _____ Work Phone # (____) _____ Ext. _____

Address _____

Street/PO Box City State Zip

SPOUSE INFORMATION

His/Her Name _____ Birthdate _____ Social Security # _____

Employer _____ Work Phone # (____) _____ Ext. _____

Address _____

Street/PO Box City State Zip

INSURANCE INFORMATION

Primary Insurance Dental Coverage? yes no

Insurance Co. Name _____ Phone # (____) _____ Group # (Plan, Local or Policy #) _____

Insurance Co. Address _____

Street/PO Box City State Zip

Insured's Name _____ Insured's Social Security # _____ Insured's Birthdate _____

Insured's Employer _____ Employer's Address _____

Street/PO Box City State Zip

Secondary Insurance Dental Coverage? yes no

Insurance Co. Name _____ Phone # (____) _____ Group # (Plan, Local or Policy #) _____

Insurance Co. Address _____

Street/PO Box City State Zip

Insured's Name _____ Insured's Social Security # _____ Insured's Birthdate _____

Insured's Employer _____ Employer's Address _____

Street/PO Box City State Zip

PHOTOGRAPHY/XRAY RELEASE

I hereby authorize you to release pictures, photographs, x-rays, films and other records in your possession that may have been made while I was your patient. Such information may be used in research, education, publication in professional journals or for any other use you deem appropriate.

Signature _____ Date _____