



Welcome to our practice! We appreciate you trusting us to meet your dental needs while providing a pleasant experience. We value your time so please complete the following information prior to your visit.

Patient Last Name: _____ First: _____ MI: _____

Preferred Name: _____ Date of Birth: _____ Sex: M _____ F _____

Marital Status: Married _____ Single _____

Spouse full Name: _____

SS# _____ Physician Name: _____

Employer: _____

Home/ mailing address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____ Email: _____

Would you like to receive text and/or email reminders for upcoming dental appointments? _____

Primary Dental Insurance: _____ Employer: _____

Subscribers Full Name: _____ SS# _____

Date of Birth: _____

Whom may we thank for referring you to our office?

Friend/Family _____

Staff _____

Website _____

Internet Search _____

Insurance _____

Facebook/Social Media _____

Phonebook/Directory _____

Other _____

In Case of an Emergency, whom would you like us to contact?

Name: _____

Phone Number: _____ Relationship: _____