Welcome . . . . . Thank you for selecting us.

To help us meet your entire healthcare needs, please fill out this form completely, in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name_____Date_____

Soc. Sec. No. _____ Birthdate _____

Home Phone_____ Work Phone_____

Address _____City_____State_____Zip_____

E-mail address_____Do we have permission to email you?_____

FaceBook account_____

Check Appropriate Box: □ Minor □Single □Married □Separated □ Divorced □ Widowed

If student, name of school or college _____City_____State_____

Patient's or Parent's Employer _____Work Phone_____

Business Address _____

City_____State_____Zip_____

Spouse or Parent's Name _____Employer _____

Work Phone _____

Whom May We Thank For Referring You?_____

Person to Contact in Case of Emergency _____ relationship _____

Contact's phone number_____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

□ Cash □ Personal check Credit Card: □ VISA □ MasterCard □AMEX

□NOVUS □ Dencharge

Dental Insurance

Employee Name_____ Employee's DOB_____

Employer :_____# of years _____

Name of Insurance Company:_____

Address:_____

Telephone:_____Program or Policy #: _____

Union Local or Group:_____ Soc. Sec. No.:_____