"Your One Stop Dental Shop"

Who may we thank for referring you? ____
How did you hear about us? ____
Do you currently have a dentist? ____
Email: ____

Patient Information

Name: ____ Birth Date: ____________________
Address: _____________________________City: ______________________State:_____ Zip:______
Home: ____________________Cell: _________________Work: _________________Ext: _________
SSN: ____________________

How would you like us to contact you? Home˙˙˙˙˙˙ Cell Work Email
GY`YWhOne:˙ Minor Single Married Divorced Separated
If patient is a minor, are parents: Married Divorced Separated Other: ___________
Emergency contact:___________________________ Home:_____________ Cell: ____________
Work: _________________ Ext.: ____________

Responsible Party

If other than patient

Name: ____ Relationship: ____________________
Address: ___________________________City: _____________________State:_____ Zip: ______
Home: _________________Cell: _________________Work: _________________Ext: _________
SSN: ____________________ Birth Date: _________________

Dental Benefits

Policy Holder: ____________________________SSSS__Relationship to patient: ______________
Address: ___________________________City: _____________________State: _____ Zip: ______
SSN: ____________________Birth Date: _________________
Employer: _________________________________Employer's Phone: _____________________
Benefits Company: ________________________________Phone______________________________
Address: ___________________________City: _____________________State:_____ Zip: ______
Group Number: _______________________________ ID Number: ________________________

Secondary Dental Benefits

Policy Holder: _____________________________SSN: _________________Birth Date: __________
Address: _____________________________City: _____________________State:_____ Zip: ______
Employer: ___________________________________Employer's Phone: _____________________
Benefits Company: _________________________________Phone___________________________
Address: _____________________________City: _____________________State:_____ Zip: ______
Group Number: _______________________________ ID Number: ________________________

X____ Date: ________________________
Signature of Patient or Parent/Guardian (if minor)