"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)