Our goal is to help you achieve and maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team of dental professionals. We will continue to warrant that trust as we serve your dental needs.

Personal Profile

Date _____ / _____ / _____

First Name _____ Middle Initial _____ Last Name _____

I like to be called _____ ❑ Male ❑ Female

Date of Birth / / Age: _____ Social Security # ___-___-____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext____

Pager_____ E-mail_____ Cell Phone _____ Fax Phone _____

What number would you like us to call you on regarding your appointments? _____

Name of Employer: _____ Occupation: _____

Address _____ City _____ State _____ Zip _____

Who may we thank for referring you to our practice?_____

Previous dentists name: _____ Phone: (____) _____

Last seen by your previous dentist? _____ Treatment rendered: _____

Would you like us to contact your previous dentist for applicable records? ❑ No ❑ Yes

Account information

Responsible party's name: _____

Address _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext____

Social Security # ___-___-____ Date of Birth / / Driver's License # _____

Insurance information - Primary

Insurance Company

Name: _____

Address _____ City _____ State _____ Zip _____

Insured's First name _____ Middle Initial _____ Last Name _____

Social Security # ___-___-____ Date of Birth / / Driver's License # _____

Insurance information - Secondary

Insurance Company

Name: _____

Address _____ City _____ State _____ Zip _____

Insured's First name _____ Middle Initial _____ Last Name _____

Social Security # ___-___-____ Date of Birth / / Driver's License # _____

Who should we contact in the unlikely event of an emergency:

Name: _____ Relationship to patient _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext____

E-mail: _____ Cell phone (optional) _____

Form #901

PATIENT REGISTRATION INFORMATION