

Patient Information

Name _____ Date ____/____/____

Address _____ City _____ Zip _____

Employer _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Best way to contact you? _____

Hobbies/Interests _____

- The purpose of your visit? _____
- Is there anything about your teeth or smile that you would like to change? _____
- Would you like more information on teeth whitening? YES / NO

Whom may we thank for referring you to our office? _____

Financial Responsibility Information (if other than patient)

Name _____ Home Phone _____

Address _____ City _____ Zip _____

Employer _____ Business phone _____

Relationship to patient _____

Dental Insurance Information

Primary Insurance

Name of insured _____ Employer _____

Insurance Company _____ Group# _____ ID# or SS# _____

Secondary Insurance

Name of insured _____ Employer _____

Insurance Company _____ Group# _____ ID# or SS# _____