Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

| 71   |  | Patient #   |
|--|--|---|
| Patient Informat                                 | 1014   | SS#/SIN   |
| i alient injormat                                | ion (Confidential)   | Date  |
| Name   | Birthdate  | Home PhoneState/ Zip/<br>ProvP.C                            |
|  | City   |   |
| Email  |  | Cell Phone  |
| Check Appropriate Box: ☐ Minor ☐.                | Single $\square$ Married $\square$ Divorced $\square$ Wid  | lowed □ Separated<br>State/ Full Part<br>Prov □ Time □ Time |
| If Student, Name of School/College               | City   | Prov. Time Time   |
| Patient or Parent/Guardian's Employer            |  | Work Phone  |
|  | The state of the s | Statel Zipl<br>Prov P.C                                     |
|  |  | Work Phone  |
| Whom may we thank for referring you:             | ?  |   |
|  |  | Phone   |
| Responsible Part                                 | V  |   |
|  | count  | Relationship<br>to Patient                                  |
|  |  | Home Phone  |
| Email  |  | Cell Phone  |
| Driver's License#                                | Birthdate Financ   | cial Institution  |
|  |  | SS#/SIN   |
| ☐ Cash ☐ Personal Check  Insurance Inform        | nation   | $\Box$ I wish to discuss the office's payment policy.       |
|  | 22   | Relationship<br>to Patient                                  |
|  |  | Date Employed   |
|  | ———— Union or Local#   | * Work Phone<br>State/ 7in/                                 |
|  | City   |   |
| Insurance Company                                | Group#   | Policy/ID#<br>State/ Zip/<br>ProvP.C                        |
| Ins. Co. Address<br>How much is vour deductible? | How much have you used?  | Prov P.C<br>Max. annual benefit                             |
|  |  | F YES, COMPLETE THE FOLLOWING:                              |
|  |  | D-1-4:1:-   |
|  |  |   |
|  |  | Date Employed   |
| Address of Employer                              | Union or Local#  | *Work Phone<br>State/ Zip/<br>ProvP.C                       |
|  | City   |   |
|  | Group#<br>City   |   |
|  |  |   |
| tion much is your deductible?                    | Over Please  | Max. annual benefit   |