Personal Information

Name

Dr.

Mr./Mrs. Date _____

Miss/Ms Last _____ First _____ MI _____

I prefer to be called _____ DOB _____

Social Security No. _____ Driver's License No. _____ State _____

Marital Status _____ Name of Spouse _____

Guarantor

Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell phone _____ E-mail _____

Home

Address _____ City _____ State _____ Zip _____

Phone _____ Cell phone _____ E-mail _____

Work

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

Other

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

Previous Dentist _____ Date last seen _____

Physician _____ Specialty _____ Date last seen _____

Insurance

Do you have dental insurance? ☐ Yes ☐ No If yes, please allow us to make copy of card

Are you covered by another insurance plan? ☐ Yes ☐ No If yes, please allow us to make copy of card

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Office Use Only

Insurance verification **Effective Date** _____

	%	Waiting period	Includes
Preventive			
Basic			
Major			

Deductible _____ Family? _____ Includes preventive? ☐ Yes ☐ No

Maximum _____ Calendar year? Fiscal year?

PePx 1/6 months 2/year

Fl 1/year 2/year

Missing tooth clause ☐ Yes ☐ No

Prosthetic replacement? _____ years

Posterior composite fillings?

Onlays covered?

Splints covered?

BwXrays 2/4/7 6 months /year

FMX Allowed _____ years Separate

Pano Allowed _____ years Combined

File electronically Yes No Payer ID#

Mailing address