

WELCOME

Our goal is to help you with your dental needs. The more we know about you the better we can care for you. Thank you for taking the time to complete these forms.

Today's Date: _____

ABOUT YOU

Name: _____

Birthdate: _____

Home Address: _____

Telephone: Home _____

Work: _____

Cell _____

E-mail: _____

SS# _____

Employer _____

Employer's Address: _____

Occupation: _____

DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co Phone # _____

Insured's Name: _____

Relationship to you: _____

Insured's Birthdate: _____

Insured's SS# _____

Insured's Employer: _____

Employer's Address: _____

HOW DID YOU HEAR ABOUT US?

Friend/Relative's Name _____

TV: ___TKO8 ___TV 26 ___Sudden Link ___Cox ___Other

Radio station: ___KHOZ ___97.1 ___96.1 ___KTLO ___104.3

Billboard ___ Website ___ Drive By ___

Insurance Network _____

Newspaper: ___Harrison ___Mtn Home ___Spotlight

Yellow Pages: ___Names & Number ___Windstream ___Ritter

Harvest Homecoming ___ Turkey Trot ___ 3rd Friday ___

Other: _____

In case of an emergency, whom should we contact?

Name: _____

Telephone Hm # _____

Wk # _____

Cell # _____

Relationship to you: _____

PERSON RESPONSIBLE FOR PAYMENT?

Me _____ Person Listed Below _____

Name: _____

Relationship to You: _____

Billing Address: _____

Group # _____

Telephone: Hm#: _____

Wk# _____

Cell # _____

E-mail: _____

SS# _____

Employer: _____