

**Personal Information**

Name: \_\_\_\_\_  
 I prefer to be called: \_\_\_\_\_  
 Single    Married    Divorced    Widowed  
 Male    Female   SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_   Age: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 PO Box: \_\_\_\_\_   Apt: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 If referred, whom may we thank? \_\_\_\_\_

**Parent's Information**

**Mother**       Step Mother       Guardian  
 Name: \_\_\_\_\_      Birthday: \_\_\_\_\_  
 Home/Cell: \_\_\_\_\_      Work: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Father**       Step Father       Guardian  
 Name: \_\_\_\_\_      Birthday: \_\_\_\_\_  
 Home/Cell: \_\_\_\_\_      Work: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Dental Insurance**

**Primary Dental Insurance**

Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 Insurance Co. Phone Number: \_\_\_\_\_  
 Member ID: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_  
 Insured's Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Insured's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_  
 Medical Insurance: \_\_\_\_\_

**Spouse Information**

Name: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Home/Cell: \_\_\_\_\_      Work: \_\_\_\_\_  
 Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Age: \_\_\_\_\_

**Dental History**

Who was your previous Dentist? \_\_\_\_\_  
 When was your last dental visit? \_\_\_\_\_  
 When were you last dental xrays taken? \_\_\_\_\_  
 Are you currently sensitive or in pain? \_\_\_\_\_  
 Do you like your smile? \_\_\_\_\_  
 How many times a day do you brush? \_\_\_\_\_  
 How many times a week do you floss? \_\_\_\_\_

**I understand that I am responsible for payment of services rendered and also responsible for any copayment and deductibles that my insurance does not cover. If my bill is placed in the hands of an attorney or collection agency for purposes of collection after default, I promise to pay all reasonable attorney's fees and all other reasonable collection fees incurred. Furthermore, if a suit is instituted to enforce collection on my bill, I promise to pay all court costs associated with said legal action.**

**Our office policy is payment in full day of service. A 5% discount is offered for cash, check or credit card payments. We accept Mastercard and Visa. We also offer third party, no interest payment plans.**

**SIGNATURE**

**DATE**

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_____	_____
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