WELCOME

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

Patient Full Name: _____ Social Security #: _____

Birth Date: ___/___/_____ Gender: ❒Male ❒Female Family Status: ❒Single ❒Married ❒Child ❒Other

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

2) HOW DID YOU FIRST HEAR ABOUT US?

Please check all that apply:

❒ Google or other search engine ❒ Angie's List ❒ Facebook ❒ Our Website ❒ Insurance ❒ Returning ❒ Postcard

❒ Walk-in/drive-by ❒ Yellow Pages/Phonebook ❒ Reardon Dental Gives Back

❒ Referred by _____ ❒ Other (please specify) _____

3) TELEPHONE & EMAIL

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

4) RESPONSIBLE PARTY

Who is responsible for this patient?

Full Name: _____ Social Security: _____

5) INSURANCE INFORMATION

Dental Coverage: ❒ Yes ❒ No Insured Birth Date ___/___/____

Insured's Name: _____ Relation: _____ Insured's SS #: _____

Insured's Employer: _____

Insurance Address: _____

Insurance Group #: _____ Insurance ID #: _____

Insurance Co. Name: _____ Insurance Co Phone #: _____

6) ACKNOWLEDGEMENT & AUTHORIZATION

I certify that I have read and understood the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE: _____DATE: ____/____/_____