Patient Information

To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health or personal information, please inform us. If you have any questions, don't hesitate to ask.

Patient Information

Patients First Name *

Patients Last Name *

Date of Birth *
mm/dd/yyyy

Social Security Number

Home Phone
(___) ___-____

Cell Phone
(___) ___-____

Work Phone
(___) ___-____

Email

Address *

City *

State *
Please sele...

Zip Code *

If the patient is a Minor, Parent's names

How did you hear about our office?

- ○ Referral
- ○ Social Media
- ○ Other

Do you want to receive reminders for appointments? Mark how you'd like to receive this.

- ○ Email
- ○ Text
- ○ Call

PATIENT CERTIFICATION AND CONSENT: I, the undersigned, certify that all the information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist.

Signature *

Today's Date
03/28/2024