

Welcome to a whole new level of oral health care! Our practice is like no other you have ever been to. We are a general dental office that focuses on comprehensive care. We believe in helping our patients develop a personalized oral health plan that will help them improve their overall health and optimize their oral health for their lifetime. So that we can best serve you and your specific needs, we ask you to complete these comprehensive forms.

### PERSONAL INFORMATION

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Business phone: \_\_\_\_\_  
 Person responsible for this account: \_\_\_\_\_  
 Is another member of your family a patient at our office? Yes  No   
 Whom may we thank for referring you? \_\_\_\_\_  
 Person to contact for an emergency? \_\_\_\_\_  
 Emergency contact phone # \_\_\_\_\_

Appointments are confirmed via (please check your preference)

- Text message       Both  
 e-mail

### INSURANCE INFORMATION

#### Primary Carrier

Insurance Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 I.D.#: \_\_\_\_\_  
 Group#: \_\_\_\_\_  
 Relationship to insured: \_\_\_\_\_  
 Insured SSN: \_\_\_\_\_  
 Insured Birthdate: \_\_\_\_\_  
 Your SSN (if different): \_\_\_\_\_

#### Secondary Carrier

Insurance Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 I.D.#: \_\_\_\_\_  
 Group#: \_\_\_\_\_  
 Relationship to insured: \_\_\_\_\_

### YOUR SPOUSE INFORMATION (for insurance reasons)

Name: \_\_\_\_\_ Business Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Business City: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### MEDICATIONS List all medications, prescription and non-prescription that you are currently taking:

Name:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SIGNATURE OF PATIENT,  
 PARENT OR GUARDIAN**

**DATE:** \_\_\_\_\_