Welcome

Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOU: Today's Date: _____

Name: _____
Last First Mi

Nickname: _____ ❑ Male ❑ Female
Birthdate: ____/____/____ Age: _____
School: _____ Grade: _____
College: _____ SS #: _____
E-mail Address: _____
Hobbies / Sports: _____
_____
Home Phone: (____) _____
Home Address: _____
_____
City State Zip
Whom may we Thank for referring you? _____
_____
Previous / Present Dentist: _____
(Please Circle)
Last visit date: _____
Other family members seen by us with Birthdate:

Name	Birthdate
_____	____/____/____
_____	____/____/____
_____	____/____/____

Who is responsible for making appointments?

Name: _____ Relation: _____
Work Phone: (____) _____
Home Phone: (____) _____

Parent Information:

Who is accompanying you today? _____
Name: _____ Relation: _____
Does this person have legal custody of you? ❑Yes ❑ No
Parent's Marital Status: (Please Circle)
Single Widowed Married Divorced Separated Partnered

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ____/____/____
Email Address: _____
Wk Phone:(____)_____ Hm Phone:(____)_____
Cell Phone:(____)_____ SS #: _____
Employer: _____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ____/____/____
Email Address: _____
Wk Phone:(____)_____ Hm Phone:(____)_____
Cell Phone:(____)_____ SS #: _____
Employer: _____

Person Responsible For Account:

Name: _____ Relation: _____
Employer: _____ DL #: _____
Wk #:(____)_____ Cell #:(____)_____
Billing Address: _____
_____
City State Zip
Previous Address: _____
_____
City State Zip

Primary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
City State Zip
Insurance Co. Phone #: (____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ___/___/__ SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____
_____
City State Zip

Secondary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
City State Zip
Insurance Co. Phone #: (____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ____/____/____SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____
_____
City State Zip

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