Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Name Birthdate Birthdate Birthdate Birthdate Birthdate Birthdate Birthdate Box: State Birthdate Box: Single Married Divorced Widowed Separated State Full Part Frow Time Tim Patient or Parent/Guardian's Employer Business Address City Prow Prow Ptc. Spouse or Parent/Guardian's Name Employer Work Phone Whom may we thank for referring you? Person to contact in case of emergency Phone Patient Address Home Phone Cell Phone Driver's License Birthdate Financial Institution Birthdate Financial Institution Statis State Birthdate Appointment. Birth greyour convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.				Patient #
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Check Appropriate Box: Minor Single Married Divorced Widowed Separated Full Part If Student, Name of School/College City Prov. Time Tim Business Address City Prov. Time Tim Work Phone State Prov. Prov. Prov. Spouse or Parent/Guardian's Name Employer Work Phone Whom may we thank for referring you? Person to contact in case of emergency Phone Responsible Party Relationship to Patient Responsible Party Responsible for this Account Relationship to Patient Responsible Party Responsible for this Account Relationship to Patient Responsible Party Responsible for this Account Relationship to Patient Relationship to Patien	Address	MAI ALL LONG	City	ProvP.C
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Is this person currently a patient in our office?	Driver's License#	Birthdate	Financial Instit	ution
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Relationship to Patient	Employer		Work Phone	SS#/SIN
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Birthdate SS#/SIN Union or Local# Work Phone State/ Zip/ Prov. P.C. Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Group# State/ Zip/ Prov. P.C. Insurance Company Group# State/ Zip/ Prov. P.C. Insurance Company Group# State/ Zip/ Prov. P.C. Insurance Insurance Company Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Name of Insured Relationship to Patient Date Employed Insurance Company Union or Local# Work Phone State/ Zip/ Prov. P.C. Insurance Company Group# Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Prov. P.C. Insurance Company Prov. P.C.				Relationship
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How much is your deductible?How much have you used?Max. annual benefit			•	State/ Zip/
DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING: Name of Insured				
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Address of Employer City State/ Prov P.C Prov P.C State/ Prov P.C State/ State/ Prov P.C Prov P.C Prov P.C Prov P.C Prov				Work Phone
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Over Please