

# Welcome

## ABOUT YOU

Today's Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
**Name:** \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  Male  Female  
Last First Mi Mr Mrs Ms Dr  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated  
**Home Address:** \_\_\_\_\_  
Street City State Zip  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Driver License #: \_\_\_\_\_  
Where & when are best times to reach you? \_\_\_\_\_ Whom may we Thank for referring you? \_\_\_\_\_  
Other family members seen by us: \_\_\_\_\_  
**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

### Neighbor or Relative not living with you

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

### Person Responsible for Account if other than yourself

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Street City State Zip

## SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance** Dental Coverage?  Yes  No Medical Coverage?  Yes  No Orthodontic Coverage?  Yes  No  
Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip  
Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

**Secondary Insurance** Dental Coverage?  Yes  No Medical Coverage?  Yes  No Orthodontic Coverage?  Yes  No  
Insurance Co. Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group # (Plan, Local or Policy #): \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip  
Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

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