B. WELL DENTISTRY

Welcome!

Patient Information **Date: _____**

Name: _____ I preferred to be called: _____
Address: _____City: _____ State: _____ Zip code: _____
Home Phone: (____)_____ Work Phone: (_____)_____ Cell Phone:(_____)_____
BEST TIME TO CONTACT ME IS: ☐ A.M. ☐ P.M. On my: ☐ Home Phone ☐ Work Phone ☐ Cell Phone
Date of Birth: _____ Social Security Number: _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Widowed, Separated, or Divorced
If a Student (Up to 26 years old) ☐ Full-time ☐ Part-time
Name of School: _____ City and State: _____
Spouse/Parent's Name: _____ Employer: _____ Work Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Email Address: _____ Would you like our newsletter? ☐ Yes ☐ No
Whom shall we thank for referring you? _____

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____ Relationship: _____
Address: _____Apt. Number: _____
City: _____ State: _____ Zip: _____ Phone: (___) _____
Employer Name: _____ Social Security Number: _____
Address: _____Work Phone: (___)_____

Insurance Information

Name of Insured: _____ Date of Birth: _____ Relationship to Patient: _____
Social Security Number: _____ Insured Employer Name: _____
Insured Employer Address: _____ Work Phone: (___) _____
Insurance Co. : _____ Group Number: _____ ID Number: _____
Insurance Mail Claims To Address: _____ Ins. Phone: (___) _____

~~~~~~~~~~~~Do You Have Additional Insurance? ☐ **Yes** ☐ **N**o **If Yes, Complete the Following**~~~~~~~~~~~~~~

Name of Insured: _____ Date of Birth: _____ Relationship to Patient: _____
Social Security Number: _____ Insured Employer Name: _____
Insured Employer Address: _____ Work Phone: (___) _____
Insurance Co. : _____ Group Number: _____ ID Number: _____
Insurance Mail Claims To Address: _____ Ins. Phone: (___) _____
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