

# About You

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely so that we may take better care of you.

Patient Name: \_\_\_\_\_ Mr Mrs Ms Dr

I prefer to be called \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Single Married Divorced Widowed Seperated

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Retired

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ How long there? \_\_\_\_\_

Where and when are the best times to reach you? \_\_\_\_\_

Where is the best place to confirm your appointments? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Other family members seen by us? \_\_\_\_\_

## ABOUT YOUR SPOUSE

Spouse Name \_\_\_\_\_ Employer Name \_\_\_\_\_

Occupation \_\_\_\_\_

## DENTAL INSURANCE

Primary Insurance:

Insurance Co. Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. Ph \_\_\_\_\_ Group # (plan, local or policy #) \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured DOB \_\_\_\_\_  
SSN \_\_\_\_\_ ID # \_\_\_\_\_  
Insured Employer \_\_\_\_\_ Employer Ph \_\_\_\_\_  
Insured Employer Address \_\_\_\_\_

Secondary Insurance:

Insurance Co. Name \_\_\_\_\_ Phone \_\_\_\_\_  
Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Co. Ph \_\_\_\_\_ Group # (plan, local or policy #) \_\_\_\_\_  
Insured Name \_\_\_\_\_ Insured DOB \_\_\_\_\_  
SSN \_\_\_\_\_ ID # \_\_\_\_\_  
Insured Employer \_\_\_\_\_ Employer Ph \_\_\_\_\_  
Insured Employer Address \_\_\_\_\_

## EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?

Name \_\_\_\_\_ Relation \_\_\_\_\_  
Wk Ph \_\_\_\_\_ Hm Ph \_\_\_\_\_

I acknowledge that i am responsible for all charges for all services provided to me, including any amount not paid by my insurantee plan or any other plan. If my insurance plan will allow direct payment to Dr. Call, I authorize him to take assignments or any unpaid dental insurance claims.

I understand that he has the right to refuse or accept assignments of dental benefits. I agree to forward him any assiged payment I receive for dental care immediately upon receipt of such payments. I also authorize the release fo all dental information necessary for processing insurance claims to my insurers or any third party of their agents.