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 insuranee 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.