baldwin city DENTAL
family & cosmetic dentistry

Welcome!

We are honored that you have selected us to provide dental care for you and your family. We look forward to working with you and getting to know you better!

PATIENT INFORMATION

Date_____

Patient's First Name_____ MI_____ Last_____ Date of Birth _____

Address_____
Street City State Zip

Home Phone_____ Marital Status_____ Social Security #_____

Cell Phone_____ E-mail Address_____

Preferred Contact Method: (We can send appointment reminders by phone, text, e-mail, or all of the above.)

Cell Phone_____ Home Phone_____ Text Message_____ E-mail_____ All_____

Are you a full-time student? Yes_____ No_____ Name of School_____

Employer_____ Occupation_____

Employer Address_____ Work Phone_____

Name of Emergency Contact (not living with you)_____ Phone_____

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION (If different from above)

Full Name_____ Relationship to Patient _____

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address?_____ Home Phone_____ Work Phone_____ Cell Phone_____

Previous Address (if less than 3 years)_____

E-mail Address_____ Social Security #_____ Date of Birth_____

Employer_____ Occupation_____

Employer Address_____ Work Phone_____

PRIMARY INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____ Date of Birth_____

Insurance Company_____ Group#_____ ID#_____

Insurance Co. Address_____ Phone#_____

Insured's Employer_____ Phone#_____

SECONDARY INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____ Date of Birth_____

Insurance Company_____ Group#_____ ID#_____

Insurance Co. Address_____ Phone#_____

Insured's Employer_____ Phone#_____