



CHOLLA

FAMILY DENTISTRY

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

About You

Name _____
(First) (MI) (Last)

Mr. Mrs. Ms. Dr. I prefer to be called: _____

Birthdate: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Single Married Divorced Widowed Separated

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

What is your preferred method of contact? _____

How did you find our office? _____

Other family members seen by us: _____

Responsible Party's Information

His/Her Name: _____
(First) (MI) (Last)

Birthdate: _____ SS#: _____

Employer: _____ Occupation: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name: _____

Relationship: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Dental Insurance

Primary Dental Insurance

Name of Insurance Co.: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Name of Insurance Co.: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____