PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Home Phone_____

How did you hear about us?_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

EMAIL CONSENT AND COMMUNICATION PREFERENCES

I agree that the dental practice may communicate electronically with me using the email listed below. I am aware that there is some level of risk that third parties may be able to read unencrypted emails.

- ✓ I am responsible for providing the dental office with any updates to my email address.
- ✓ I can withdraw my consent to electronic communications by calling 763-786-3432.
- ✓ Our office now sends billing statements via email. If we do not have an email on file for you, statements will be sent by standard mail.

Patient Email (Please Print Clearly): _____@_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email [ ] Text

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email [ ] Text

Patient Signature:_____ Date:_____