

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 [] Email [] Text

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

Patient Signature: _____ Date: _____