WELCOME WAUSHARA DENTAL ASSOCIATES, S.C.

PATIENT INFORMATION

Name: _____
Last *First* *MI*

I prefer to be addressed as: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

Date of Birth: _____ Gender ☐ M ☐ F

Social Security #: _____

Driver's License #: _____

Mailing Address: _____

City _____ State ____ Zip Code _____

E-mail Address: _____

For confirmation of appointments and company information only. We take your privacy very seriously.

Home Phone: (____)_____

Cell Phone: (____)_____Work: (___)_____

Can we reach you at your work number? ☐ Yes ☐ No

Employer: _____

Emergency Contact: _____

Relationship: _____

Telephone: (___)_____Work: (___)_____

MINOR/GUARDIAN ACCT INFORMATION

Person Responsible for the Account

Name: _____

Relation to Patient: _____

Billing Address: _____

City: _____State: _____ Zip Code: _____

Social Security #: _____ D.O.B.: _____

Telephone: (___)_____ Work: (___)_____

PREFERRED METHOD OF CONTACT

Please choose one:

☐ E-mail ☐ Text ☐ Call

Circle One: Home or Cell

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Dental Insurance Company:_____

Subscriber Name:_____

Subscriber D.O.B.:_____

Insurance Co. Phone #:(___)_____

Subscriber's Employer:_____

Group #:_____

Subscriber ID or Social Security #:_____

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child

Secondary Dental Insurance (if applicable)

Dental Insurance Company:_____

Subscriber Name:_____

Subscriber D.O.B.:_____

Insurance Co. Phone #:(___)_____

Subscriber's Employer:_____

Group #:_____

Subscriber ID or Social Security #:_____

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child

Patient/Guardian Signature: _____ Date: _____