

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain optimum dental health. Please fill out this confidential form completely. The better we communicate, the better we can care for you.

ABOUT YOU	1
Today's Date _____ PATIENT'S NAME _____ I prefer to be called _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated Birth Date ____ / ____ / ____ Age _____ SS# _____ HOME ADDRESS _____ _____ City _____ State _____ Zip _____ TELEPHONE NUMBERS Hm # _____ Cell# _____ Wk # _____ Other _____ Email _____ Preferred Contact# <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Other EMPLOYER Employer's Address _____ _____ Occupation _____ How long _____	
SPOUSE INFORMATION	
His / Her Name _____ Employer _____ Wk # _____ SS # _____ Birth Date ____ / ____ / ____	

PRIMARY DENTAL INSURANCE	2
Insurance Co. _____ Ins. Address _____ City _____ State _____ Zip _____ Ins. Phone # _____ Group # _____ Insured's Name _____ Ins. Bithday _____ Ins. ID # _____ Ins. Employer _____ Address _____ City _____ State _____ Zip _____	
SECONDARY DENTAL INSURANCE	
Insurance Co. _____ Ins. Address _____ City _____ State _____ Zip _____ Ins. Phone # _____ Group # _____ Insured's Name _____ Ins. Bithday _____ Ins. ID # _____ Ins. Employer _____ Address _____ City _____ State _____ Zip _____	

ACCOUNT INFORMATION	4
Person responsible for account His / Her Name _____ Work # _____ Hm # _____ Address: _____ City _____ State _____ Zip _____	

GETTING TO KNOW YOU	3
Whom may we thank for referring you? _____ _____ Other family members seen by us. _____ _____ Previous dentist _____ Person to contact for emergency _____ _____ Phone _____	

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Backer / Dr. Slaybaugh to furnish information to my insurance company concerning my care. I further hereby assign all payments for dental services rendered to me, or my dependents, by the above insurance company. I understand that I am fully responsible for any portion of those services not covered by my insurance benefits.

Date _____ Signature of Authorized Person _____