OPEN DOOR
FAMILY DENTISTRY

Welcome

Thanks for choosing us to help you with your smile

About you

Name: _____ Date:_____

I prefer to be called: _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Child

Home Phone #_____ Cell Phone #_____

Email Address: _____

How would you like us to remind you of your appointments?

☐ Home phone call ☐ Cell Phone call ☐ Text message

Birthdate:_____/___/_____Age:_____ Soc. Sec# _____

Address: _____

City:_____ State:_____ Zip code: _____

Patient's or Parent's Employer_____ Work Phone #_____

Business Address: _____ City:_____ State:____ Zip:_____

Spouse or Parents name:_____ Employer:_____

Work phone: _____

Person to contact in case of an emergency: _____ Phone #_____

How did you hear about our practice? _____

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Responsible Party

Name of person responsible for this account:_____

Relationship to patient: _____

Address:_____City:_____State:_____Zip: _____

Home Phone#:_____Cell Phone#: _____

Birthdate:____/____/_____Soc.Sec.#_____

☐ Single ☐ Married ☐ Child

Driver's License#: _____

Employer:_____Work Phone: _____

Check your preferred method of payment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ I wish to discuss the Office's payment plan

Insurance information

Name of insured:_____Relationship to Patient: _____

Birthdate:____/____/_____Soc.Sec.#:_____Date Employed: _____

Name of Employer:_____Union or Local #:_____Phone #: _____

Insurance Company:_____Group#:_____Policy#: _____

Address:_____City:_____State:_____Zip: _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of insured:_____Relationship to patient: _____

Birthdate:_____/____/_____Soc.Sec.#:_____Date Employed: _____

Name of Employer:_____Union or Local#: _____

Work phone: _____