WELCOME TO OUR DENTAL OFFICE

To more efficiently serve you, we will require the following information. All information is kept strictly confidential.

PATIENT INFORMATION

DATE: ______________

LAST NAME:_______________________FIRST NAME:_______________________ MIDDLE INITIAL:_____

DOB: _________ AGE: _____ SS#: _________________ SEX:_____ MARITAL STATUS: (S) (M) (D) (W)

ADDRESS:____

CITY:____ST:_________________________ZIP:___________

EMAIL ADDRESS: _______________________________________

WHO MAY WE THANK FOR REFERRING YOU? ____

PREFERENCE FOR APPOINTMENT REMINDERS: (CIRCLE ONE) (EMAIL) (TEXT) (PHONE CALL)

HOME PHONE: (____)___________ CELL PHONE: (_____)__________ WORK PHONE:(____)__________________

OKAY TO CALL WORK? (YES) (NO) OCCUPATION: ____

EMPLOYER: _______________________________ ADDRESS: ____

NAME OF SPOUSE: _____________________________________

PREVIOUS DENTIST: _____________________ ADDRESS: ____

ARE RECORDS AVAILABLE TO US FROM PREVIOUS OFFICE? (YES) (NO) PHONE: (____)_____________________

PERSON TO CONTACT IN CASE OF EMERGENCY:____

HOME PHONE: (____)___________ CELL PHONE: (_____)__________ WORK PHONE:(____)___________________

BILLING/INSURANCE INFORMATION

RESPONSIBLE PARTY/POLICY HOLDER:__________________________________ SS#: ____________________________

RESPONSIBLE PARTY/POLICY HOLDER DOB:_______________RELATIONSHIP TO PATIENT:________________________

ADDRESS:____CITY:___________ST:____ZIP:_________

HOME PHONE:(____)___________ WORK PHONE:(____)_____________EMPLOYER:____________________________

DO YOU HAVE DENTAL INSURANCE? (YES) (NO)

PERSONAL INFORMATION

BRIEFLY TELL US ABOUT YOURSELF: ____

WHAT ARE YOUR HOBBIES? ____

IS THERE ANYTHING THAT WE SHOULD KNOW ABOUT YOU THAT WOULD MAKE YOUR VISIT MORE COMFORTABLE?

____

Upon signing below, I authorize my insurance benefits to be paid to Dr. Kifer. I am financially responsible for any balance due and authorize the dentist to release any information for this claim. I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form, read and understand the financial policy and HIPAA privacy forms for our office.

SIGNATURE: ____ DATE:____________________________