WELCOME TO OUR DENTAL OFFICE

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

PATIENT INFORMATION

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 ALL THAT APPLY): (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 INFORMATION/ INSURANCE INFORMATION

RESPONSIBLE PARTY/POLICY HOLDER:_____ **SS# or Member #:** _____

RESPONSIBLE PARTY/POLICY HOLDER DOB:_____ **RELATIONSHIP TO PATIENT:**_____

ADDRESS:_____ **CITY:**_____ **ST:**____ **ZIP:**_____

HOME PHONE:(____)_____ **WORK PHONE:(____)**_____ **EMPLOYER:**_____

DO YOU HAVE DENTAL INSURANCE? (YES) (NO) **IS POLICY HOLDER RESPONSIBLE FOR ACCOUNT? (YES) (NO)**

INS. CO. NAME _____ **PHONE#** _____

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?

_____

***If you would like to allow any of your information to be discussed/released to another individual(s), please list their name(s) and relationship to you below:**

Name of Personal Representative(s) _____

Relationship to Patient _____

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 and read and understand the financial policy.

SIGNATURE: _____ **DATE:**_____