

# WELCOME TO WELLS FAMILY DENTISTRY

*Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental healthcare needs, please fill out this form  
completely in ink. If you have any questions or need assistance, please ask us -  
we will be happy to help.*

## Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Date \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time  
Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Is this person currently a patient in our office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?

Yes  No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

*Over Please*

