

# Welcome



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 # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

## Patient Information (CONFIDENTIAL)

Date \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_ Cell phone \_\_\_\_\_

Check Appropriate Status:

\_\_\_\_\_ minor \_\_\_\_\_ single \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ widowed \_\_\_\_\_ separated

If Student, Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_ Full time student \_\_\_\_\_ Part time student

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parents 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 \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birth date \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS # \_\_\_\_\_

Is this person currently a patient in our office? \_\_\_\_\_ Yes \_\_\_\_\_ No

For your convenience, we offer the following payment options. Please check the option you prefer. Payment in full is expected at each appointment. I understand that my insurance is an agreement between myself and my insurance company. I also understand that I am responsible for my balance regardless of my insurance. Thank you for your cooperation.

\_\_\_\_\_ Cash \_\_\_\_\_ Personal Check \_\_\_\_\_ Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Discover \_\_\_\_\_ AMEX

\_\_\_\_\_ I wish to apply for outside credit.

**Over Please**

## *Insurance Information*

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*How Much is your deductible?* \_\_\_\_\_

*How much have you used?* \_\_\_\_\_

*Maximum Annual Benefit* \_\_\_\_\_

*I understand that my insurance is an agreement between myself and my insurance company.  
I also understand that I am responsible for my balance regardless of my insurance. I assign dental benefit  
payments to be paid directly to Dr. Joseph B. Brogdon from my insurance company.*

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*DO YOU HAVE ANY ADDITIONAL INSURANCE?* \_\_\_\_\_ YES \_\_\_\_\_ NO

*IF YES COMPLETE THE FOLLOWING:*

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Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*How Much is your deductible?* \_\_\_\_\_

*How much have you used?* \_\_\_\_\_

*Maximum Annual Benefit* \_\_\_\_\_

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*I give my permission for this office to use any before and after photos, or study models (stone models of your  
teeth) for internal promotional purposes, teaching lectures, presentations, or publication.*

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*Patient Signature* \_\_\_\_\_ *Date* \_\_\_\_\_