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Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME _____ PREFERRED NAME _____

Male Female Social Security No. _____ - _____ - _____ Birthdate ____/____/____

Mailing Address _____ Email _____

City _____ State _____ Zip Code _____ Home Phone No. (____) _____

Cell Phone No. (____) _____ How should we contact you? Home Work Cell Email

Married Single Divorced Separated Widowed

Patient Occupation _____ Employer _____ Work Phone (____) _____

Name of Spouse _____ Birthdate ____/____/____ SSN _____

Spouse Occupation _____ Employer _____ Work Phone (____) _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name _____ Home Ph. No. (____) _____ Work Ph. No. (____) _____

Relationship to patient _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

Cash Check Bankcard Insurance

Person responsible for payment: _____

Primary Dental Insurance

Employee _____

Relationship to Patient _____

Employer _____

Insurance Co. _____ Group# _____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

Secondary Dental Insurance

Employee _____

Relationship to Patient _____

Employer _____

Insurance Co. _____ Group# _____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

I have been given and understand the Harmony Family Dentistry HIPPA Notices of Privacy Act.

Signature _____ Date _____