Welcome!

QDW#:______________________________

Patient Information

Patient Name: LAST: ________________________ FIRST: ________________________M.I. ____ School:__________

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Social Security Number: ________________________

Last Dental Visit: ____/____/____ Reason For Visit:________________________ Last X-rays Taken: ____/____/____

Last Dentist's Name: ______________________________ City: ____________________ Phone (___) ______-________

Reason for today's visit/chief dental complaint: ____

Responsible Party Information

Name: LAST: ________________________ FIRST: ________________________ M.I.: ___ Relationship: _________

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Social Security Number: ____________________

Address Street: ____ Apartment #: ____________

City: ____ State: ______________ Zip Code: ______________

Home Phone No.: (_____) ________________ Mom's Cell: (_____) _______________ Dad's Cell (_____) ______________

Mom's Work No.: (_____) ________________ Dad's Work No.: (_____) ________________ E-mail: __________________

Emergency contact other than family member: Name________________________ Phone: (________) ________________

Who may we thank for referring you to our office: ☐ Internet ☐ Flier ☐ Passing By ☐ Mailer

☐ Patient: ________________________ ☐ Doctor: ________________________ ☐ Other: ________________________

Please List All Members Of Your Immediate Family

Family Member's Full Name	Now A Patient In This Office?		Date of Birth	Relationship to Patient
1.	☐ Yes	☐ No		
2.	☐ Yes	☐ No		
3.	☐ Yes	☐ No		
4.	☐ Yes	☐ No		

Primary Dental Insurance Information

Insured's Name: ____

Insured's Date of Birth: ______/______/______

Insured's Social Security Number: ______________________

Insured's Employer:______________________________________

Insured's Employer Phone No.: (______) ________________

Insurance Company Name: ______________________________

Insurance Company Phone No: (______) ________________

Insurance Group No.: ________________ Local: ___________

Secondary Dental Insurance Information

Insured's Name: ____

Insured's Date of Birth: ______/______/______

Insured's Social Security Number: ______________________

Insured's Employer: ______________________________________

Insured's Employer Phone No.: (______) ________________

Insurance Company Name: ______________________________

Insurance Company Phone No: (______) ________________

Insurance Group No.: ________________ Local: ___________

Our office is collecting ethnic and racial information in order to develop systems and staff to provide the best quality of care to all of our patients. To do this we ask that you make the most appropriate selection regarding the race and ethnicity from the choices listed below. This information is voluntary and confidential.

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Race:
☐ White
☐ Black
☐ Native American/Eskimo/Aleut
☐ Asian/Pacific Islander
☐ Other: ________________
☐ Unknown

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all charges regardless of insurance coverage. I hereby authorize the Dental Office to administer such medications including the use of local anesthetic and to perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are true and correct to the best of my knowledge. I hereby authorize the Dental Office to release my dental/medical information and other information about my dental treatment to third party payors and other health professionals.

Signature: ________________________________ Driver's Lic #: ________________ State: ____ Date: _____/_____/_____
(If a minor, parent or legal guardian)