Schmidt Family Dentistry Inc.

Today's Date: _____

Thank you for joining our family of patients and friends. Our goal is to provide excellent comprehensive dental care to patients in a friendly compassionate environment. We are dedicated to educating and guiding our patients toward making good decisions regarding their dental health, and are committed to continuing our professional education to stay current with the latest advances in dentistry. Please complete this form so that we can provide the best possible care for you.

ABOUT YOU

Name: _____ ☐ Female ☐ Male

Nickname: _____ If Child – Parent's Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Birthdate: ___/___/___ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Email Address: _____ Social Security Number: _____

Other family members in this practice? _____

Who is responsible for payment of this account? _____

EMERGENGY INFORMATION

Person to contact: _____ Relationship: _____ Phone: _____

HOW DID YOU FIND US?

☐ Insurance Company ☐ Website ☐ Sign on Building ☐ Referral – Who can we thank? _____

DENTAL INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Address: _____ Phone: _____

Name of Policy Holder: _____ Policy Holder's birth date: ___/___/___

Relationship of policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder's ID/social security #: _____ Group #: _____

Policy Holder's employer: _____ Employer's address: _____

Name of Secondary Insurance Company: _____

Address: _____ Phone: _____

Name of Policy Holder: _____ Policy Holder's birth date: ___/___/___

Relationship of policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder's ID/social security #: _____ Group #: _____

Policy Holder's employer: _____ Employer's address: _____

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