

Welcome,

The benefits of a happy and healthy smile are immeasurable. Our goal is to help you reach and maintain this. Please complete these forms. With good communication, we can better care for you. Dr. Bob & Dr. Peg

About You

Name: _____

Preferred Name: _____

Home Address: _____

Home Phone # _____

Cell Phone # _____

Social Security # _____

Birth date: _____ [] Male [] Female

Marital Status: [] S [] M [] D [] W

Your Employer: _____

Occupation: _____

Work Phone # _____ Ext _____

Whom may we thank for referring you to our office: _____

About Your Spouse

(If you are married, please complete this section)

Your Spouse's Name: _____

Their Cell Phone # _____

Their Employer: _____

Their Occupation: _____

Their Work Phone # _____

Emergency Information

(Please name someone other than spouse)

Name: _____

Relationship: _____

Home Phone # _____

Cell or Work Phone # _____

Dental Insurance

Do you have dental insurance through your employer? [] Yes [] No

(If yes, please complete this section.)

Insurance Co.: _____

Ins. Address: _____

Ins. Co. Phone # _____

Your Employer: _____

Your Group # _____

Dental Insurance

Do you have other dental insurance coverage?

[] Yes [] No

(If yes, please complete this section.)

Cardholder Name: _____

Relationship: [] Spouse [] Parent [] Other

Their Birth date: _____

Their Social Security # _____

Their Work Phone # _____

Their Employer: _____

Their Group # _____

Insurance Co.: _____

Ins. Address: _____

Ins. Co. Phone # _____

I understand that the information I have given is correct. I authorize release of information for insurance, appointment scheduling and confirmation. I understand that I am responsible for all costs of my dental treatment, and direct payment to Drs. Slovic & Sujack.

(Signed)

(Date)