Today's Date:____/____/ _____

WELCOME

We are pleased to welcome you to Columbia City Dentists. To help us meet your dental needs, please fill out this form completely.

Patient Information

Patient Name:_____ DOB:_____/_____/ _____

Address:_____ SSN: _____-_____-_____

City: _____ State: _____ Zip: _____

Home: (____)_____- _____ Cell: (____)_____- _____ Work: (____)_____- _____

Email: _____

This information will not be shared. It is strictly for confirming appointments and updating you on news with our office.

How would you like your appointments confirmed: ☐ Phone Call ☐ Email ☐ Text

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor

How did you hear of our office: _____

Guarantor Information

(Leave blank if the patient is the guarantor)

Name:_____ DOB:_____/_____/ _____

Address:_____ SSN: _____-_____-_____

City: _____ State: _____ Zip: _____

Home: (____)_____- _____ Cell: (____)_____- _____ Work: (____)_____- _____

Gender: ☐ M ☐ F Relationship: ☐ Spouse ☐ Child ☐ Dependent ☐ Other _____

Insurance Information

Name of Insured:_____ DOB:____/____/ _____

Social Security Number:_____-_____-_____ ID #: _____

Insurance Company:_____ Employer: _____

Insurance Phone Number: (____)_____-_____ Group #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other

If you have a secondary insurance, please fill in the section below. Otherwise, please continue to the next page.

Name of Insured:_____ DOB:____/____/ _____

Social Security Number:_____-_____-_____ ID #: _____

Insurance Company:_____ Employer: _____

Insurance Phone Number: (____)_____-_____ Group #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other