WELCOME

Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Oswego Dental Care, we are committed to keeping your private healthcare information confidential.

Today's Date: _____

Person Financially Responsible for Account (parent's name if minor):

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____

❑ Male ❑ Female Birthdate: ____/____/____ Age: _____

Social Security #: _____

Driver's License #: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: (____)_____ Pager: (____) _____

Work Phone: (____)_____ Ext: _____

Cell Phone: (____) _____

E-mail: _____

Employer:

Employer's Name: _____

Employer's Address: _____

_____
City State Zip

Length of employment: _____

Occupation: _____

When are the best times to reach you? _____am _____pm

Whom may we thank for referring you? _____

_____

Second Person Responsible for Account/Spouse:

Name: _____ Birthdate: ____/____/____

Employer: _____

Driver's License #: _____

Work Phone: (____)_____ Home Phone: (____) _____

Relationship: _____

Social Security #: _____

Billing Address: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Birthdate: ____/____/____

Relationship to Patient: _____

Insured's SS #(required): _____

Insured Insurance ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number *(Plan, Local or Policy #)*: _____

Insured's Name: _____ Birthdate: ____/____/____

Relationship: _____

Insured's SS #: (required) _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

In the event of any emergency, whom should we contact?

Name: _____

Relation: _____

Work Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
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