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 ❑ Other _____

Birthdate: ____/____/____ Age: _____

Social Security #: _____

Driver's License #: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

❑ Single ❑ Married

Home Phone: _____ Cell: _____

Work Phone: _____ Ext: _____

E-mail: _____

Employer:

Employer's Name: _____

Employer's Address: _____

_____
City State Zip

Occupation: _____

Second Person Responsible for Account/Spouse:

Name: _____

Employer: _____

Contact Phone: _____

Relationship: _____

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
Patient Name	Date of Birth	Sex	Age	Social Security Number