Patient Name: _____ Patient ID:_____

Do you have a referral? Yes ☐ NO ☐

If yes, referring dentist:

Full Name:_____

Address:_____

_____

Phone number:_____

E-mail:_____

(Information needed to refer you back to your family dentist.)

What are you here for?

Endodontic ☐ Oral Surgery ☐ Orthodontic ☐ Pediatric ☐ Sedation ☐

Why are you here?

Consultation ☐ Treatment ☐ Second opinion ☐

Do you have insurance? In Network ☐ Out Of Network ☐

If yes: Insurance Company: _____

Employer: _____

Policy Holder: _____

Social Security Number: _____

Group Number: _____

ID Number: _____

Phone Number: _____

_____ _____

Patient/Guardian Signature: Date

Employee initials: _____