

# Welcome

Thank you for selecting Coastal Dentistry!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## Patient Information (CONFIDENTIAL)

SS# \_\_\_\_\_  
Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom May We Thank for Referring You? \_\_\_\_\_  
Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # of Insurance Co. \_\_\_\_\_

What did you like about your last dental visit? \_\_\_\_\_

Was there anything you did not like? \_\_\_\_\_

What can we do to help make your visits more comfortable? \_\_\_\_\_

Is there anything else we should know (time, cost, etc.)? \_\_\_\_\_

Over Please