Welcome to Azalea City Dental

Date: _____/_____/_____

1) Tell Us About You:

Title: Mr. o Mrs. o Miss o Ms. o Dr. o

Last Name_____First_____Middle_____

Address_____ City, State _____ Zip _____

Marital Status: Single o Married o Other o Date of Birth _____/_____/_____ SSN _____-_____-_____

Driver's License # _____ Place of Employment_____

2) Contact Information:

Email address (to confirm appointments): _____

Phone: HM _____ WK _____ Cell _____

Emergency contact: Name _____ Relationship_____ Phone _____

3) How Did You Hear About Our Office?

- ○ Family Member: Name_____
- ○ Friend: Name _____
- ○ Website
- ○ Yellow Pages
- ○ Mail
- ○ Newspaper
- ○ Street Sign
- ○ Other: _____

4) Account Information:

Are you financially responsible for this account?

○**Yes** (Go to Section 5) ○ **No** (Complete the following):

Person responsible: _____

Relationship _____

Address_____

City, State _____ Zip _____

Date of Birth _____/_____/_____ SSN_____-_____-_____

Email _____ Phone _____

5) Primary Dental Insurance

Insurance Company Name _____ Telephone _____

Insurance Company Address _____ City, State_____ Zip_____

Group Number _____ Policy Holder's Employer _____

Policy Holder's Name _____ Relationship to Patient _____

Policy Holder's Date of Birth _____/_____/_____ Policy Holder's SSN _____-_____-_____

6) Do You Have Secondary Insurance? ○ Yes ○ No