

**WELCOME
TO
Bluff Creek Dental**

ABOUT YOU

Today's Date: ___/___/___

Patient Name: _____
Last First MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ___/___/___ Age: ___ SS# _____

Mailing Address: _____

City State Zip

Home Phone # _____

Other Phone #'s _____

E-Mail Address: _____

Referred By: _____

Employer: _____

Occupation: _____

Minor Single Married Divorced Separated Widowed

Full-Time Student No Yes School Name: _____

Spouse's Name: _____

Spouse's Work # _____ Birthdate: ___/___/___

Insurance Info

Primary Dental Insurance

Co. Name: _____

City State Zip

Phone #: _____

Insured SS#: _____

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

Insured's Name: _____

Relation: _____ Birthdate: ___/___/___

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

City State Zip

Phone#: _____

Insured SS# _____

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

Insured's Name: _____

Relation: _____ Birthdate: ___/___/___

Insured's Employer: _____

Account Info

Person financially responsible for account

Name: _____

Relation: _____

Billing Address: _____

City State Zip

SS#: _____ Birthdate: ___/___/___

Work Phone #: _____

INIT I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office) and for any finance charge that may be applied for late balances

IN THE EVENT OF AN EMERGENCY

Who should be contacted? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____