PATIENT INFORMATION: (Please Print)

Name: _____Nickname: _____ Birthdate: _____

Legal Sex:* M____F____ Preferred pronouns _____

*While Wohl Family Dentistry recognizes a number of genders and sexes, many insurance companies and legal entities do not.

Please be aware that the legal name and sex you have listed on your insurance must be used on all documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ _____Soc. Sec #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____ Occupation: _____

Preferred method of contact (please check) Home___Work___Cell___Email___

INSURANCE/FINANCIAL INFORMATION:

Person Responsible for account: _____

Relationship to patient: _____ Birthdate: _____ Soc. Sec #: _____

Subscriber Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Dental Insurance Company: _____ Subscriber ID: _____ Group #: _____

If no Dental Insurance, please specify payment type: Cash: _____ Check: _____ C.C: _____

Names of other family members and relationships:

_____

In Case of Emergency Contact: _____ Relation: _____ Phone: _____

Whom may we thank for referring you to our office?

Name: _____ Relationship: _____ Address:_____

Please note that payment is expected at the time of your visit. For our patients with dental insurance, please provide us with your insurance card so that we may keep a copy on file. If we are able to accept your insurance company's assignment, we will gladly do so and will provide with you an estimate as a guideline. We can make no guarantee of the amount of payment by your insurance company. Claims are submitted promptly after the treatment has been rendered.

I agree to be fully responsible for total payment of procedures performed in this office, including any portion not covered by my insurance company.

Signature: _____ Date: _____

PLEASE COMPLETE MEDICAL AND DENTAL HISTORY ON THE REVERSE SIDE. THANK YOU.