115 Parnell Street, Merritt Island, FL 32953
Phone: 321-452-8190 Fax: 321-454-4822

WELCOME TO OUR OFFICE

Thank *you for choosing our dental team to take care of your oral health. Please fill out this form completely, so that we may provide you with the best possible care.*

(Please Print)					
Today's date:					
PATIENT INFORMATION					
Patient's last name:	**First:**	**Middle:**	❑ **Mr.** ❑ **Mrs.**	❑ **Miss** ❑ **Ms.**	**Marital status (circle one)** ❑**Single** ❑ **Mar** ❑ **Div** ❑ **Sep** ❑ **Wid**
Preferred Name:			Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security #:		Home Phone #: ( )	
				Work Phone #: ( )	
Apt/PO Box #:	City:	State:	ZIP Code:	Cell Phone #: ( )	
Do you prefer being contacted by: ❑ Phone ❑ Email		Email Address:			
Reason for visit or concerns:					
Last dental visit or exam:					
Name of prior Dentist:					
Who may we thank for referring you to our practice? (please list name):					
Referring Doctor:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist)					
Is this patient covered by insurance?	❑ Yes	❑ No			
Name of Insured (if different from above):	Birth date: / /	Address (if different from above):		Home phone # (if different): ( )	
Primary insurance Carrier Name and Address:			Phone # on back of card: ( )		
Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	ID #:	Policy #:	Group #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Employer's: Name:	Employer's Address:		Employer's Phone #: ( )		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living with you):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.			
Patient/Guardian signature		**Date**	