

# Welcome

## Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.  
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

**TELL US ABOUT YOU:** Today's Date: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Mi

Nickname: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

College: \_\_\_\_\_ SS #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Hobbies / Sports: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_

City State Zip

Whom may we Thank for referring you? \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

Last visit date: \_\_\_\_\_

Other family members seen by us with Birthdate:

Name Birthdate

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

**Who is responsible for making appointments?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

**Parent Information:**

Who is accompanying you today? \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Does this person have legal custody of you?  Yes  No

Parent's Marital Status: (Please Circle)

Single Widowed Married Divorced Separated Partnered

**Mother's Information:**  Step Mother  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Email Address: \_\_\_\_\_

Wk Phone: (\_\_\_\_) \_\_\_\_\_ Hm Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

**Father's Information:**  Step Father  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Email Address: \_\_\_\_\_

Wk Phone: (\_\_\_\_) \_\_\_\_\_ Hm Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

**Person Responsible For Account:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State Zip

Previous Address: \_\_\_\_\_

City State Zip

**Primary Dental Insurance:**

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Policy Owner: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_/\_\_\_/\_\_\_ SS #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

**Secondary Dental Insurance:**

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Policy Owner: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_/\_\_\_/\_\_\_ SS #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

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