

## WELCOME TO WOLFTEVER DENTAL

Thank you for selecting our dental team! We will always work hard to earn the trust that you have placed in us. To help us meet your dental needs please fill out these forms for us. Yes, we hate forms too, but this information is important.

### PERSONAL INFORMATION

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Wish to be called: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

( ) Male ( ) Female

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

( ) Single ( ) Married

Social Security #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

If the patient is a minor, please tell us about you, the parent or guardian:

Your Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Your Address: \_\_\_\_\_

Your Home Phone #: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Your Social Security #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Birthdate: \_\_\_\_\_

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

Cell Phone #: \_\_\_\_\_

### EMPLOYER INFORMATION

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

Business Phone: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Business E-mail: \_\_\_\_\_

If Student, Name of School: \_\_\_\_\_

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

### INSURANCE INFORMATION

Name of Insured Person: \_\_\_\_\_

Plan Name or #: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_

Group # / Effective Date: \_\_\_\_\_

Social Security # of Insured: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

If you have additional Insurance please complete the following:

Name of Insured Person: \_\_\_\_\_

Plan Name or #: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_

Group # / Effective Date: \_\_\_\_\_

Social Security # of Insured: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Patient's (Guardian's) Signature:

\_\_\_\_\_  
Date: