Welcome

❖❖❖ LANDMARK DENTAL CENTER ❖❖❖

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. Please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help you.

Patient Information

Name ______________________ Birthdate ______________________ Home Phone (_____)______________________

Address______________________ City______________________ State____________ Zip ______________

Email ______________________ Cell Phone (_____)______________________ Alt. Phone (_____)______________________

Sex ☐ M ☐ F Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Minor SS# ______________________

Employer/School ______________________ Employer/School Phone (_____)______________________

Employer/School Address ______________________ City______________________ State ____________ Zip ______________

Spouse or Parent/Guardian Name ______________________ Work Phone (_____) ______________________

Whom May We Thank for Referring You? ______________________

Person to Contact In Case of Emergency ______________________ Phone (_____) ______________________

Responsible Party (If a Minor)

Name of Person Responsible for This Account______________________ Relationship to Patient ______________________

Address ______________________ Phone (_____) ______________________

Email ______________________ Birthdate ______________________ SS# ______________________

Employer ______________________ Work Phone (_____) ______________________

Is This Person Currently a Patient in Our Office? ☐ Yes ☐ No

For Your Convenience, We Offer The Following Methods of Payment. Please Check The Option You Prefer. Payment In Full at Each Appointment.

☐ Cash ☐ Check Credit Card ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express ☐ Care Credit

Insurance Information

Name of Insured ______________________ Relationship to Patient ______________________

Birthdate ______________________ SS# ______________________ Date Employed ______________________

Employer Address ______________________ City ______________ State ______________ Zip ______________

Insurance Company ______________________ Subscriber ID# ______________________ Group # ______________________

Secondary Insurance

Name of Insured ______________________ Relationship to Patient ______________________

Birthdate ______________________ SS# ______________________ Date Employed ______________________

Employer Address ______________________ City ______________ State ______________ Zip ______________

Insurance Company ______________________ Subscriber ID# ______________________ Group # ______________________