West Bend Dental

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call.

Today's Date_____

Patient Information (Confidential)

Name_____
First Middle Last

Address_____
Street P.O. Box

_____
City State Zip Code

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Sex: ____Male ____Female **Marital Status:** ____Married ____Single ____Divorced ____Separated ____Widowed

Date of Birth_____ **Social Sec. #**_____ **Drivers Lic. #**_____

Employer_____ **Employer Phone #**_____

Preferred Pharmacy:_____ **E-mail Address**_____

Responsible Party Information (if someone other than the patient)

Name_____
First Middle Last

Address_____
Street P.O. Box

_____
City State Zip Code

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Sex: ____Male ____Female **Marital Status:** ____Married ____Single ____Divorced ____Separated ____Widowed

Date of Birth_____ **Social Sec. #**_____ **Drivers Lic. #**_____

Primary Insurance Information	Secondary Insurance Information
Name of Insured:	Name of Insured:
Name of Insurance Co.:	Name of Insurance Co.:
Relationship to Patient:	Relationship to Patient:
Social Sec. # or ID#:	Social Sec. # or ID#:
Date of Birth:	Date of Birth:
Employer:	Employer:
Employer Address:	Employer Address:
City, State, Zip:	City, State, Zip:
Group #:	Group #:

I acknowledge the receipt of the Notice of Privacy Practices (HIPAA). Date: _____ *Signature:* _____