

# Welcome to House Family Dentistry

So that we may better serve your health care needs, please take a moment to answer the following questions.

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
first middle/maiden last

Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ -Male -Female

Employer/school: \_\_\_\_\_ Work phone: \_\_\_\_\_

-Minor child -Adult -Married Spouse's name: \_\_\_\_\_  
-Widowed -Separated -Divorced Spouse's employer: \_\_\_\_\_

Person responsible for your dental account: \_\_\_\_\_

Relationship to patient: -Self -Spouse -Parent -Child -Other \_\_\_\_\_

Responsible party's date of birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Dental plan: \_\_\_\_\_ Phone: \_\_\_\_\_

Group name: \_\_\_\_\_ Group number: \_\_\_\_\_ Effective date: \_\_\_\_\_

Dental plan address: \_\_\_\_\_

Whom may we thank for referring you to Dr. House? \_\_\_\_\_

Thank you for trusting us to provide for your dental needs. It is our pleasure to serve you, your family, and friends.

\_\_\_\_\_  
Date Signature

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Office staff to complete this section

Patient deductible: \_\_\_\_\_ Account deductible: \_\_\_\_\_ Patient maximum: \_\_\_\_\_ per \_\_\_\_\_

Waiting period: \_\_\_\_\_ for \_\_\_\_\_

Coverage for dependents: \_\_\_\_\_

Coverage: Cleanings \_\_\_\_\_ per \_\_\_\_\_ fmx \_\_\_\_\_ per \_\_\_\_\_ bw per \_\_\_\_\_

Sealants: \_\_\_\_\_ per \_\_\_\_\_ until age \_\_\_\_\_

Flouride: \_\_\_\_\_ per \_\_\_\_\_ until age \_\_\_\_\_ Orthodontics @ \_\_\_\_\_

Basic @ \_\_\_\_\_ Major @ \_\_\_\_\_ Prosthetics @ \_\_\_\_\_