

Welcome to Wellspring Dental. We sincerely appreciate you choosing our office for your health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

Please tell us about yourself

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Who may we thank for referring you to us for care? _____

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

Your Name: _____

Your Address: _____

City: _____ State: _____ Zip: _____

Today's Date: _____

Home Phone: _____

Date of Birth: _____ Sex: M F

Social Security #: _____

Do you have dental insurance? Yes No

Relationship to Patient: _____

Your Home Phone: _____

Your Social Security #: _____

Employer Information

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Business Phone: _____

Your Position: _____

How long with company? _____

Spouse Information

Spouse's Name: _____

Spouse's Address: _____

City: _____ State: _____ Zip: _____

Spouse's Employer: _____

How long has your spouse been employed at his/her current company? _____

Spouse's Soc. Sec. #: _____

Spouse's Date of Birth: _____

Business Phone: _____

Insurance Information

Name of Insurance Co: _____

Name of Insured Person: _____

Social Security Number of Insured Person: _____

Plan Name or Number: _____

Group No./Effective Date: _____

Insured Date of Birth: _____

AUTHORIZATION for TREATMENT: This is to certify that I, the undersigned Patient or Guardian, consent to all medical procedures agreed to between myself and Wellspring Dental, including the use of local, inhalational, sedative or general anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. Wellspring Dental, at its discretion, may elect to assess me finance charges, not to exceed 1.5% per month, on any balances that are over 60 days past due.

Patient's (Guardian's) Signature

Date