We Care Dental
Kevin M. Donlin, D.M.D.
wecaredental.com

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Patient Information

Patient Name: _____ Prefer To Be Called: _____

Gender (M/F): _____ Birth Date: _____ /_____ /_____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Business Address: _____ # Of Years There: _____

Marital Status: _____ Spouse's Name: _____ Birth Date: _____ / _____ / _____

Dependent's Name(s) and Birth Date(s): _____

_____

Contact In Case Of An Emergency: _____ Phone #: _____

If Patient Is A Minor, Give Parent(s) or Guardian(s) Name: _____

Whom May We Thank For Referring You To Our Office: _____

If Not A Referral, How Did You Hear About Our Office: _____

Responsible Party Information

Person Responsible for this Account and Billing

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Dental Insurance Information

Name of Policy Holder: _____ Social Security #: _____

Insurance Company: _____ Birth Date: _____ / _____ / _____

Policy Holder's Employer Name: _____ Phone #: _____

ID #: _____ Group #: _____

Address: _____

Name of Secondary Policy Holder: _____ Social Security #: _____

Secondary Insurance Company: _____ Birth Date: _____ / _____ / _____

Policy Holder's Employer Name: _____ Phone #: _____

ID #: _____ Group #: _____

Address: _____

What was the approximate date of your last dental check-up? _____

Please list anything else that we should know about your health: _____

_____

What are your main concerns about this visit? _____

_____

What is your reaction to dentistry (worry a little, dread it, don't mind it)? _____

_____

If you have recently left another dentist, may we inquire your reasons for leaving? _____

_____

Please initial next to each authorization pertaining to accurate patient information, assignment of benefits, and release of information, and then sign below.

_____ I have reviewed the information in this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist at my next appointment.

_____ I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

_____ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ **Date:** _____

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR DENTAL NEEDS!