

Witt Family Dentistry

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WELCOME

1

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Date _____
SS#/SIN _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Separated Divorced Widowed
If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

2

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Birthdate _____ SS#/SIN _____
Employer _____ Work Phone _____
For your convenience, we offer the following methods of payment.
Cash Personal Check Credit Cards: VISA MasterCard Discover I wish to discuss the office's payment policy.

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INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

