Broadlands *family* Dentistry

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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ SS/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birth Date _____ ☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birth Date _____ ID#/SS# _____

Address (If different from patients) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____ Contract # _____ Group # _____

Subscriber ID # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address (If different from the patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____