

Welcome to Our Practice!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs

About You

Date: _____ Male Female
Full Name: _____ (Nickname) _____
DOB: ____/____/____ Social Security # _____ - _____ - _____
Home Address: _____
Street _____ Suite/Apt # _____
City/Town _____ State _____ Zip _____
Home Phone # _____ Cell Phone# _____
Work Phone: _____ Email: _____
Employer: _____ If a student, name of school _____
If under 18, person responsible for account: _____
Emergency Contact: _____
Name _____ Telephone # _____
Whom may we thank for referring you? _____

Your Dental Insurance

Primary Dental Insurance Carrier Name _____
Named Subscriber on policy: _____
Subscriber ID Number: _____ Policy Group # _____
If you are NOT the subscriber, please answer the following:
Subscriber DOB: ____/____/____ Subscriber SS# _____ - _____ - _____
Relationship to you: _____
Subscriber Employer/Group Plan Name _____

If you have secondary dental insurance, please fill in below

Secondary Dental Insurance Carrier Name _____
Named Subscriber on Policy: _____
Subscriber ID #: _____ Policy Group # _____
Subscriber DOB: ____/____/____ Subscriber SS# _____ - _____ - _____
Relationship to you: _____
Subscriber's Employer/Group Plan Name: _____

The information on this page is correct to the best of my knowledge. I hereby authorize Waverley Dental Care to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I hereby authorize Waverley Dental Care to submit my dental treatments to my insurance company for payment on my behalf. I grant the right to Waverley Dental Care to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____ Date _____
Signature of Patient or Responsible Party

Secondary Dental Insurance

Secondary Dental Insurance Carrier _____

Named Subscriber on policy: _____

Subscriber ID Number: _____

If you are NOT the subscriber, please answer the following:

Subscriber DOB: ____/____/____ Subscriber SS# ____ - ____ - _____

Relationship to you: _____ Group # _____

Subscriber's Employer/Group Plan Name: _____