



# Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 M.I.\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Cell: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Employment Status:**  
 Full Time  Part Time  Retired   
 Employer: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Sex: Male  Female   
 Marital Status:  
 Married  Single  Divorced  
 Separated  Partnered   
 Widowed   
 Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_  
 Soc. Sec. #: \_\_\_-\_\_\_-\_\_\_\_  
 If college student, name and city of college: \_\_\_\_\_  
 Student Status:  
 Full Time  Part Time   
 Referred by: \_\_\_\_\_  
 Former Dentist: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

## Spouse Information

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Work Phone: Soc. Sec.: \_\_\_-\_\_\_-\_\_\_\_  
 Birth Date: \_\_\_/\_\_\_/\_\_\_

## Relative/Friend not living with you

Name: \_\_\_\_\_  
 Relation: \_\_\_\_\_  
 Home Ph: \_\_\_\_\_  
 Work Ph: \_\_\_\_\_

## Responsible Party (if a minor)

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 M.I.\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Cell: \_\_\_\_\_  
 Birth Date: \_\_\_/\_\_\_/\_\_\_  
 Soc. Sec. #: \_\_\_-\_\_\_-\_\_\_\_  
 Responsible Party is Policy Holder   
 Primary Insurance Policy Holder   
 Secondary Insurance Policy Holder

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_

Relationship to Patient:

Self  Spouse

Child  Other

Insured's Soc. Sec #: \_\_\_\_-\_\_\_\_-\_\_\_\_\_

Insured's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Insured's Address: \_\_\_\_\_

\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Name Insurance Co: \_\_\_\_\_

Insurance Co Address: \_\_\_\_\_

\_\_\_\_\_

Ins Phone #: \_\_\_\_\_

Grp. # \_\_\_\_\_

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_

Relationship to Patient:

Self  Spouse

Child  Other

Insured's Soc. Sec #: \_\_\_\_-\_\_\_\_-\_\_\_\_\_

Insured's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Insured's Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Name Insurance Co: \_\_\_\_\_

Insurance Co Address: \_\_\_\_\_

\_\_\_\_\_

Ins Phone #: \_\_\_\_\_

Grp. # \_\_\_\_\_

Why have you come to the dentist today? \_\_\_\_\_

Are you happy with the way your smile looks? \_\_\_\_\_ If not, what would you change? \_\_\_\_\_

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

Because this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Villaggio Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

**I have received a copy of Villaggio Dental's Notice of Privacy Practices. I have also been offered/received a copy of the Dental Materials Fact Sheet as required by law.**

**I understand that the information that I have given today is correct to the best of my knowledge.**

I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Office Use Only**

I have reviewed the medical/dental information of the patient named herein.