

Welcome to Ablantis Dental. We sincerely appreciate you choosing our office for your dental and oral health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form.

## Please tell us about yourself

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

e-Mail Address: \_\_\_\_\_

Who may we thank for referring you to us for care? \_\_\_\_\_

Today's Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F

Social Security #: \_\_\_\_\_

Do you have Dental Insurance? Yes No

### If the Patient is a minor, please tell us about you, the parent or guardian:

Your Name: \_\_\_\_\_

Your Address: \_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_

Your Home Phone #: \_\_\_\_\_

Your Social Security #: \_\_\_\_\_

## Employer Information

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

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

Business Phone: \_\_\_\_\_

Your position: \_\_\_\_\_

How long with company: \_\_\_\_\_

## Spouse Information

Spouse's name: \_\_\_\_\_

Address: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

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

Spouse's Soc.Sec. #: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_

Business Phone: \_\_\_\_\_

How long with company: \_\_\_\_\_

## Insurance Information

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

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

Social Security # of Insured: \_\_\_\_\_

Plan Name or Number: \_\_\_\_\_

Group No./ Effective Date: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_