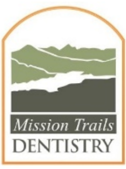

Welcome to MISSION TRAILS DENTISTRY

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (Confidential) Social Security #:___________________Email:______________ Date:_____________

Name: ____ Birthdate: _________________

Home Phone: ____________________________________ Cell Phone: ____

Address: __________________________________ City: ____________________ State: _____________ Zip: ________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, School/College Name: _______________ City: _______________ State: ______________ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer: ____ Work Phone: ______________________

Occupation: _______________Business Address: ____________________ City: _____________ State: ____ Zip: ________

Spouse or Parent's Name: _____________________ Employer: ________________ Work Phone: _____________________

Whom May We Thank for Referring You? ____

Person to Contact in Case of Emergency: ________________Relation to Patient: ______________ Phone: ______________

Responsible Party

Name of Person Responsible for This Account: ______________________________ Relationship to Patient: ____________

Address: ____ Home Phone: ____________________

Driver's License #: _______________________ Birthdate: ____________

Employer: _____________________________ Work Phone: __________ SS#: __________________________________

Insurance Information

Name of Insured: _________________________________ Relationship to Patient: ________________________________

Birthdate: _______________________ Social Security #:____________________ Date Employed: __________________

Name of Employer: ____________________ Union or Local #: _________________ Work Phone: ____________________

Insurance Company: _____________________________ Group #: _____________ Policy/ID#:______________________

Ins. Co. Address: ___________________________ City: ____________________ State: ______________ Zip: ________

What Is Your Deductible? ____________ How Much Have You Used? ______________ Max. Annual Benefit: ____________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured: _________________________________ Relationship to Patient: ________________________________

Birthdate: _______________________ Social Security #:____________________ Date Employed: __________________

Name of Employer: ____________________ Union or Local #: _________________ Work Phone: ____________________

Insurance Company: _____________________________ Group #: _____________ Policy/ID#:______________________

Ins. Co. Address: ___________________________ City: ____________________ State: ______________ Zip: ________

What Is Your Deductible? ____________ How Much Have You Used? ______________ Max. Annual Benefit: ____________