



spring dental group ltd.

5440 Spring St. Racine, WI 53406 Phone (262) 886-9440

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 your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # \_\_\_\_\_

Social Sec. # \_\_\_\_\_

Date \_\_\_\_\_

Email Address \_\_\_\_\_

Cell Phone \_\_\_\_\_

### Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How would you like us to address you? \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Relative to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Marital Status \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ E-mail \_\_\_\_\_ Fax# \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

### Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

NOTE: If you receive Direct Reimbursement from your insurance carrier, payment at time of service is expected. The patient portion of charges are also due at time of service.

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_