ELLIFF DENTAL
FAMILY & COSMETIC DENTISTRY

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.
We look forward to working with you and maintaining your dental health.

Patient Information

Last Name_____ First Name_____ MI_____

□ Male □ Female □ Married □ Single □ Child □ Other_____

Birth Date____/____/_____ Soc. Sec. # _____ DL #_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

Emergency Contact

Name_____ Relationship_____

Home Phone_____ Cell Phone_____ Work Phone_____

Insurance Policy Holder Information

□ Information is the same as patient information

Last Name_____ First Name_____ MI_____

□ Male □ Female □ Married □ Single □ Child □ Other_____

Birth Date____/____/_____ Soc. Sec. # _____ DL #_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

Insurance Information

Insured Employer Name_____ Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Patient's Relationship to Insured □ Self □ Spouse □ Child □ Other_____

Insurance Company_____ Phone Number_____

Insurance Address_____ City_____ State_____ Zip_____

ID#_____ Group #_____ Subscriber #_____

Referral Information

Whom may we thank for referring you to our office?

□ Another Patient □ Website □ Work □ Insurance Company □ Mr. Coupon

□ Other_____ Name of Person_____