Welcome to

We're so glad you're here!

Please fill out this confidential form completely in ink.

Patient Information:

Date:_____/________/_________

Who can we thank for referring you, or how did you hear about us?____

First Name: __________________________ Last Name:_______________________ Middle Name: ____________________

Birthdate:____/______/_______ Social Security:_______/____/_______ Driver's License #:___________________________

Street Address:_______________________________City:_________________ State:______________ Zip:_____________

Home Phone:___________________ Cell Phone:_______________________ Email:________________________________

Patient's Employer: ____ Work Phone: ____________________ Ext:________

Business Address: ___________________________________ City: ____________________ State: ______ Zip: ___________

Spouse's Name: ______________________________ Employer: ________________________ Work Phone:______________

Emergency Contact:___________________________Realtionship:______________________Phone:___________________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Male ☐ Female

If Student, Name of School/College: ______________________ City________________ State ____ ☐ Full Time ☐ Part Time

Responsible Party / Primary Insured Policy Holder (if someone other than patient):

Name/Policy Holder:____ Relationship to Patient: __________________

Address: ____ Best Contact Phone: __________________________

Drivers License #:_________________________________ Birthdate: _____/____/_____ Soc. Sec. #_______/_____/________

Employer: ____ Work Phone: ___________________________________

Insurance Company:_____________________________Address:_________________________Phone:__________________

Secondary Insurance Information:

Policy Holder Name: ______________________________________ Relationship to Patient: _____________________

Address: ____ Best Contact Phone: ____________________

Drivers License #:_____________________ Birthdate: ______/_____/________ Soc. Sec. #_______/_____/________

Employer: ____ Work Phone: ______________________________

Insurance Company:____________________________Address:________________________Phone:_____________

Payment is due in full at time of service. Wilkinson Dental offers the following payment options.

Please check the option you prefer: ☐ Cash ☐ Personal Check Credit Cards: ☐ VISA ☐ MasterCard ☐ CareCredit

Preferred Methods of Contact (for appointment reminders):

☐ Mail ☐ E-mail ☐ Texting Phone: ☐ Home ☐ Cell ☐ Work