

Adair Family Dentistry

Healthy and Beautiful Smiles Begin Here

Welcome

On behalf of Dr. Will Adair and his dental team, we are pleased to welcome you to our practice. Please take a few minutes to provide us with the following information. All information will be kept confidential.

Patient Information

Patient Name: _____

Email: _____ Home Phone: _____

Work: _____ Cell: _____

Social Security #: _____ DOB: _____

Gender: Male Female Marital Status: Single Married Divorced Widowed

Address: _____

City: _____ Zip: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact Person: _____ Phone: _____

Are you a student: FT PT How did you hear about our office? _____

Responsible Party Information

Person Responsible for Account: _____ Relationship to patient _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ Zip: _____

Social Security #: _____ DOB: _____ Driver License#: _____

Have you or any member of your family been a patient at this office before? yes no

If YES please give us their name _____

Primary Dental Insurance

Insured's Name: _____

SS#: _____ INS Carrier: _____

Group or Policy #: _____ Date Employed: _____

Secondary Dental Insurance

Insured's Name: _____

SS#: _____ INS Carrier: _____

Group or Policy #: _____ Date Employed: _____