WHO DOES YOUR TEETH? DR. JEFFREY NEAL & TEAM

WELCOME FORM

PATIENT INFORMATION

Patient Last Name:	First Name:	Preferred Pronoun: ❑ He / Him ❑ She / Her ❑ They / Them	Title: ❑ Mr. ❑ Mrs. ❑ Dr. ❑ Ms.	Relationship Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widowed ❑ Separated

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	I prefer to be called:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address: Apt #:	Social Security #:		Home phone: ( )
City:	State:	Zip Code:	Cell phone: ( )
Occupation:	Employer:		Work phone: ( )

Email Address:

The Best Way to Contact me: ❑ Email ❑ Text Message ❑ Cell Phone ❑ Home Phone ❑ Work Phone

How Did You Hear About Us?

Whom May We Thank for Referring You?

FINANCIAL & INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for Financial:	Birth date: / /	Address (if different):	Best phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Insurance Co Provider:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's name:	Subscriber's S.S. no.:	Subscriber's Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Partner ❑ Child

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Partner ❑ Child

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Who Does Your Teeth.
I understand that I am financially responsible for any balance. I also authorize Who Does Your Teeth? Dr. Jeffrey Neal & Team or my insurance company to release any information required processing my claims.

Patient/Guardian signature *Date*