WHO DOES YOUR TEETH? DR JEFFREY NEAL & TEAM

WELCOME FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's Last name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Relationship status (circle one) Single / Mar / Div / Sep / Part
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:	Social Security no.:		Home phone no.: ( )		
City:	State:	Zip Code:	Cell phone no.: ( )		
Occupation:	Employer:		Work phone no.: ( )		
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 to process my claims.

Patient/Guardian signature *Date*