Thank you for choosing Van Haren Family Dentistry! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

DATE________________

NAME____**BIRTHDATE**___________________**SS #**____________________

ADDRESS____**CITY**_________________**STATE**_______**ZIP**___________

HOME PHONE __________________________CELL PHONE _____________________________WORK PHONE__________________________
(Circle preferred phone)

EMAIL____Who may we thank for referring you?___________________________________

Person to contact in emergency______________________________________**RELATIONSHIP**_________________**PHONE**__________________

Check Appropriate Boxes Minor College Student Single Married Divorced Widowed Separated

PARTY FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (IF DIFFERENT THAN PATIENT)

NAME____**BIRTHDATE**___________________**SS #**____________________

ADDRESS____**CITY**_________________**STATE**_______**ZIP**___________

HOME PHONE __________________________CELL PHONE _____________________________WORK PHONE__________________________
(Circle preferred phone)

EMAIL____**RELATIONSHIP TO PATIENT**_____________________________________

PRIMARY DENTAL INSURANCE (IF ANY)

SUBCRIBER NAME____**RELATIONSHIP TO PATIENT**______________________________

ADDRESS (if diff than patient)____CITY_________________STATE_______ZIP___________

DOB_______________________**SS #**_____________________________ EMPLOYER____

INSURANCE CO____**GROUP #**________________**CONTRACT #**___________________

INSURANCE CO ADDRESS____INSURANCE PHONE_____________________

SECONDARY DENTAL INSURANCE (IF ANY)

SUBCRIBER NAME____**RELATIONSHIP TO PATIENT**______________________________

ADDRESS (if diff than patient)____CITY_________________STATE_______ZIP___________

DOB_______________________**SS #**_____________________________ EMPLOYER____

INSURANCE CO____**GROUP #**________________**CONTRACT #**___________________

INSURANCE CO ADDRESS____INSURANCE PHONE_____________________