



Thank you for choosing Van Haren 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 _____	REFERRAL SOURCE _____		
PREFERRED PHARMACY _____			
Person to contact in emergency _____		RELATIONSHIP _____	PHONE _____
Check Appropriate Boxes <input type="checkbox"/> Minor <input type="checkbox"/> College Student <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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)			
SUBSCRIBER 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)			
SUBSCRIBER NAME _____	RELATIONSHIP TO PATIENT _____		
ADDRESS (if diff than patient) _____	CITY _____	STATE _____	ZIP _____
DOB _____	SS # _____	EMPLOYER _____	
INSURANCE CO _____	GROUP # _____	CONTRACT # _____	
INSURANCE CO ADDRESS _____	INSURANCE PHONE _____		