Welcome to Boise Family Dental Care

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain good oral health. Please fill out this form completely. The more we know about you, the better we can care for you!

I. Tell Us About You (Patient):

Today's Date: _____/_____/_____

Last Name: _____First Name: _____Middle Initial: _____ Mr. /Mrs. /Ms.

Birthdate: _____/_____/_____ SS#: _____-_____-_____

Height: _____ Weight: _____ lbs.

Home Address: _____City: _____

State: _____ Zip: _____ Home Phone#: _____ Cell#: _____

Employer: _____ Occupation: _____

Work#: _____ Ext: _____ Previous Dentist: _____

May we contact you by e-mail? Yes / No E-mail Address: _____

How long has it been since your last cleaning? _____

When and where are we most likely to reach you? _____

Is there a name you prefer to be called other than the one listed above?_____

II. Spouse Information (If patient is a minor, Parent Information):

His/Her Name: _____ D.O.B._____

Employer: _____ Work#:_____ Ext: _____

Social Security #:_____Cell#_____

III. Dental Insurance:

*PRIMARY DENTAL INSURANCE:_____

Insurance Co. Phone #:_____Group#:_____

Insured's Name: _____ Social Security #:_____

Insured's Birthday: _____ Relation to patient: _____

**SECONDARY DENTAL INSURANCE: _____

Insurance Co. Phone #: _____Group#:_____

Insured's Name: _____ Social Security #:_____

Insured's Birthday: _____ Relation to patient: _____

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status or other information. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

I hereby authorize payment of my insurance benefits, otherwise payable to me, to the dentist listed on this form. I authorize the use of this signature on all insurance submissions. I understand I am responsible for any unpaid balance on my account. Payment due at time of service is an **estimate** of what my insurance will not pay.

_____

Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please do not hesitate to ask.

We are happy to help! ☺

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.