# *Welcome*

Please read this information carefully. If you have any questions regarding this form, please ask our staff for assistance. We look forward to working with you in maintaining your dental health.

Name_____
FIRST MIDDLE INITIAL LAST

Address_____

City_____ State_____ Zip Code_____

Home_____ Office_____ Mobile_____

Birth Date_____ Social Security Number _____

(circle) Male / Female (circle) Single / Married / Separated / Divorced / Widowed

Notify in case of emergency _____

Relationship_____ Phone Number_____

Whom may we thank for referring you? _____

## Insurance Information

Name of Insured _____Relationship to Patient_____

Birth Date_____ ID/Subscriber #_____

Employer_____ Insurance Co. _____

I assign my dental insurance benefits to Dr. Rodney Shivers and authorize release of any necessary dental records to my insurance company.

Signature_____ Date_____