

Alaska Comprehensive **D**ENTAL Center

Welcome! Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Today's Date: _____

Name: _____ Nick Name: _____ Birth date: _____

Soc. Sec. #: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City/Zip: _____

E-Mail: _____ Employer: _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated Other _____

If Student Name of School/College: _____ City/State: _____ Full Time Part Time

Spouse, Parents or Nearest Relative Name: _____ Contact Number: _____

Contact in Case of Emergency: _____ Contact Number: _____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account if Other Than You: _____

Address: _____ City/Zip: _____ Contact Number: _____

Birth date: _____ Soc. Sec. #: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Currently a Patient in Our Office? Yes No

Dental Insurance Information

Name of Person Carrying Insurance: _____ Birth date: _____

Soc. Sec. #: _____ Name of Employer: _____ Union or Local #: _____

Work Phone: _____ Relationship to Patient: Self Spouse Child Other: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____ Ins. Co. Phone Number: _____

Do You Have Any Additional Dental Insurance? Yes No If Yes, Complete the Following:

Name of Person Carrying Insurance: _____ Birth date: _____

Soc. Sec. #: _____ Name of Employer: _____ Union or Local #: _____

Work Phone: _____ Relationship to Patient: Self Spouse Child Other: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____ Ins. Co. Phone Number: _____