WELCOME

to

Bay Hill Dental, Ltd.

==========

Patient Information

*Name*_____ *Preferred Name*_____ *Date* _____

Birthdate _____ *SSN* _____ *Gender: Male / Female*

*Address*_____ *City* _____ *State* _____ *Zip* _____

Phone# (Home) _____ *(Cell)* _____ *(Work)* _____ *Email*_____

Please circle appropriate: Minor Single Married Divorced

Patient or Parent/Guardian Employer _____

Business Address _____

Person to Contact in Case of Emergency _____ *Phone* _____

Whom May We Thank for Referring You? _____

==========

Responsible Party

Name of Person Responsible for this Account _____ *Relationship to Patient*_____

SSN _____ *Email*_____

Address _____

Employer _____

Phone# (Home) _____ *(Cell)* _____ *(Work)* _____

==========

Insurance Information

Insured (Subscriber's) Name _____ *Relationship to Patient* _____

Insurance Carrier Name _____ *Insurance Phone Number* _____

Insurance Company Address _____*Group#*_____

Subscriber's Birth Date _____ *SSN* _____ *Subscriber ID#* _____

Name of Employer _____ *Work Phone #* _____

==========