Wellness Springs Dental® of Salem ***Today's Date:*** ______________

Patient Information

Name: ____ **Birth Date:** ____________________
Last First MI Nickname

Gender: ❒ Male ❒ Female **Family Status:** ❒ Married ❒ Single ❒ Other **Social Security Number:** __________________

Address: ____
Street Apt # City State ZIP

Home Phone: ______________________________ **Work Phone:** ______________________ ext ________

Cell Phone: ______________________________ **E-mail address:** ______________________________

Occupation: ❒ Homemaker ❒ Retired ❒ Full-time Student ❒ Other: ______________________________

Employer & Address: ____

Responsible Party Information

Name: ____ **Birth Date:** ____________________
Last First MI Nickname

Relationship to Patient: ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian

Gender: ❒ Male ❒ Female **Family Status:** ❒ Married ❒ Single ❒ Other **Social Security Number:** __________________

Address: ____
Street Apt # City State ZIP

Home Phone: ______________________________ **Work Phone:** ______________________ ext ________

Cell Phone: ______________________________ **E-mail address:** ______________________________

Occupation: ______________________ **Employer & Address:** ______________________________________

Insurance Information

Primary Insurance:

Name of Insured: ____ **Is Insured a patient?** ❒ Yes ❒ No

Insured's Birth Date: ______________ **Relationship to Patient:** ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian

Insurance: __________________________________ **Group #:** ____________ **ID#:** ________________

Insured's Address (if different than patient's): ____

Secondary Insurance:

Name of Insured: ____ **Is Insured a patient?** ❒ Yes ❒ No

Insured's Birth Date: ______________ **Relationship to Patient:** ❒ Patient ❒ Spouse ❒ Parent ❒ Legal Guardian

Insurance: __________________________________ **Group #:** ____________ **ID#:** ________________

Insured's Address (if different than patient's): ____

Referral Information

Whom may we thank for referring you to our practice? Please give us their name, so we can thank them!

❒ Another patient ❒ Newspaper ❒ Postcard ❒ Letter ❒ Insurance ❒ Friend/Relative ❒ Other: ____________________

Name of Person or office who referred you: ____