

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 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!

# Welcome!

## Patient Information (CONFIDENTIAL)

**NAME** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_  
\_\_\_\_\_  
**ADDRESS** \_\_\_\_\_ **HOME**  
**PHONE** \_\_\_\_\_  
**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**CELLULAR** \_\_\_\_\_  
**CHECK APPROPRIATE:** \_\_\_\_\_ **MINOR** \_\_\_\_\_ **SINGLE** \_\_\_\_\_ **MARRIED** \_\_\_\_\_ **DIVORCED** \_\_\_\_\_  
**WIDOWED** \_\_\_\_\_ **SEPARATED** \_\_\_\_\_  
**IF STUDENT, NAME OF SCHOOL/COLLEGE** \_\_\_\_\_ **CITY** \_\_\_\_\_  
\_\_\_\_\_  
**PATIENT OR PARENT EMPLOYER** \_\_\_\_\_ **WORK PHONE** \_\_\_\_\_  
\_\_\_\_\_  
**BUSINESS ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_  
\_\_\_\_\_  
**SPOUSE OR PARENT'S NAME** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
\_\_\_\_\_  
**PERSON TO CONTACT IN CASE OF EMERGENCY** \_\_\_\_\_ **EMPLOYER** \_\_\_\_\_  
\_\_\_\_\_  
**PHONE** \_\_\_\_\_  
\_\_\_\_\_  
**WHOM MAY WE THANK FOR REFERRING YOU?**  
\_\_\_\_\_  
\_\_\_\_\_  
**E-MAIL:** \_\_\_\_\_ **I WOULD LIKE TO**  
**RECEIVE APPOINTMENT REMINDERS VIA E-MAIL** **YES** **NO**

## Responsible Party

**NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_ **HOME**  
**PHONE** \_\_\_\_\_

**DRIVER'S LICENSE #** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_  
**FINANCIAL INSTITUTION** \_\_\_\_\_  
**EMPLOYER** \_\_\_\_\_ **WORK PHONE** \_\_\_\_\_  
**SSN #** \_\_\_\_\_  
**IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?**     **YES**     **NO**  
**FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT. PLEASE CHECK THE OPTION YOU PREFER.**  
 **PAYMENT IN FULL AT EACH APPOINTMENT**     **MASTER CARD, VISA OR DISCOVER**     **I WISH TO DISCUSS OTHER OPTIONS**

## Insurance Information

**NAME OF INSURED** \_\_\_\_\_ **RELATIONSHIP TO PATIENT** \_\_\_\_\_  
\_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_  
**NAME OF EMPLOYER** \_\_\_\_\_ **WORK PHONE** \_\_\_\_\_  
\_\_\_\_\_ **SSN #** \_\_\_\_\_  
**ADDRESS OF EMPLOYER** \_\_\_\_\_ **CITY** \_\_\_\_\_  
\_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**INSURANCE COMPANY** \_\_\_\_\_  
\_\_\_\_\_  
**INSURANCE CO. ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_  
\_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**GROUP #** \_\_\_\_\_ **POLICY NAME OR #** \_\_\_\_\_  
\_\_\_\_\_  
**DEDUCTIBLE** \_\_\_\_\_ **MAX. ANNUAL BENEFIT** \_\_\_\_\_  
\_\_\_\_\_

## Secondary Insurance (if applicable)

**NAME OF INSURED** \_\_\_\_\_ **RELATIONSHIP TO PATIENT** \_\_\_\_\_  
\_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_  
**NAME OF EMPLOYER** \_\_\_\_\_ **WORK PHONE** \_\_\_\_\_  
\_\_\_\_\_ **SSN #** \_\_\_\_\_  
**ADDRESS OF EMPLOYER** \_\_\_\_\_ **CITY** \_\_\_\_\_  
\_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**INSURANCE COMPANY** \_\_\_\_\_  
\_\_\_\_\_  
**INSURANCE CO. ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_  
\_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**GROUP #** \_\_\_\_\_ **POLICY NAME OR #** \_\_\_\_\_  
\_\_\_\_\_  
**DEDUCTIBLE** \_\_\_\_\_ **MAX. ANNUAL BENEFIT** \_\_\_\_\_  
\_\_\_\_\_

**THOR J. ANDERSON, DDS. SC | 1520 VERNON ST. | STOUGHTON WI 53589 | 608-873-7277 | [WWW.THORANDERSONDDS.COM](http://WWW.THORANDERSONDDS.COM)**