WELCOME
to
Cary Dental Associates

Please bring this completed form with you to our office for your first visit. We look forward to working with you in maintaining your dental health.

Name: _____ Soc. Sec. #: _____
Last First Initial

Address: _____City_____

State: _____ Zip: _____ Home Phone: _____ Email_____

Cell Phone: _____ May we text you: Y or N Work Phone: _____

Sex: M or F Age: _____ Birthdate: ____/____/____ Marital Status: _____

Whom may we thank for referring you? _____

Notify in case of emergency: _____

DENTAL INSURANCE

(Please bring a copy of your Dental Insurance Card this may be diff than your medical carrier, please verify)

Primary Policy Holder: _____
Last First Initial

Relation to Patient: _____ Birthdate: ____/____/____ Soc Sec #: _____

Address (if different from patient):_____

Home Phone: _____ Cell Phone: _____ Email:
_____

Policy Holder Employed by: _____ Occupation: _____

Business Address: _____ Phone #: _____

Dental Ins. Co: _____ Phone #: _____

Claims mailing address: _____

Group #: _____ Subscriber /Carrier I.D.#: _____

DENTAL HISTORY

Former Dentist: _____ Phone #: _____

Date of last Dental visit: ____/____/____ Date of last x-rays: ____/_____/____
(Please have x-rays forwarded to info@carydentalassociates.com prior to your first visit or new sets will be taken)