WELCOME! Thank you for selecting In-Home Dental Care, Inc. We will strive to provide you with the best possible dental hygiene 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.

Personal Information

Name(Last, First, MI)________________________________ Date______________

SSN#______________________ Birthdate______________________

E-mail____

Wishes to be called____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Address____

City__________________ State/Prov.______________ Zip______________

Employer______________________ Occupation______________________

Referred by____

Home Phone____

Work Phone______________________ Ext #______________________

Cell Phone____

Emergency Name/Contact Number___________________________

Medicaid Insurance Information	**Other Dental Insurance**
Name of Insured	Name of Insured
Insured's birthdate	Relationship to patient
SSN#	Insured's birthdate
Medicaid #	SSN#
Effective Dates	Employer
	Date Employed
	Occupation
	Insurance Company
	Group #
	Employee/Cert #
	Ins. Co. Address

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental care giver of any changes in medical status.

I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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SIGNATURE OF PATIENT, PARENT, OR GUARDIAN/CARE TAKER DATE