AGAVE DENTAL

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

About You

Name _____
(First) (MI) (Last)

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. I prefer to be called: _____

Birthdate: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Cell: _____ Home Phone: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

What is your preferred method of contact? Please circle: Phone Text Email

Who may we thank for referring you _____

Other family members seen by us: _____

Responsible Party's Information

His/Her Name: _____
(First) (MI) (Last)

Birthdate: _____ SS#: _____

Employer: _____ Occupation: _____

Cell: _____ Home Phone: _____

Work Phone: _____ Email: _____

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name: _____

Relationship: _____

Cell: _____ Home Phone: _____

Email: _____

Dental Insurance

Primary Dental Insurance

Name of Insurance Co.: _____

Address: _____

_____

Phone #: _____

Group #: _____

Policy Holder Name: _____

Relation to policy holder. Please circle: Self Spouse Child Other

Insured's Birthdate: _____ Member ID# or SSN: _____

Insured's Employer: _____

Secondary Dental Insurance

Name of Insurance Co.: _____

Address: _____

_____

Phone #: _____

Group #: _____

Policy Holder Name: _____

Relation to policy holder. Please circle: Self Spouse Child Other

Insured's Birthdate: _____ Member ID# or SSN: _____

Insured's Employer: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Number: _____