LEGACY SMILES
Family Dental

Patient Information

Today's Date: ____/____/____

Full Legal Name: _____ Preferred Name: _____

Date of Birth: ____/____/____ Phone Number (primary): _____

Social Security Number:_____ Gender: ☐ Male ☐ Female ☐ Prefer not to say

Email Address: _____

Contact Information

Address: _____
Street City State Zip

Preferred Contact Method: ☐ Call ☐ Text ☐ Email

Appointment Reminders: ☐ Call ☐ Text ☐ Email

Any other communication preferences or needs: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone: _____ Email: _____

Responsible Party *(if different from patient)*

Name: _____ Relationship to Patient: _____

Phone: _____ Email: _____

Address: _____
Street City State Zip

Insurance Information

Primary Insurance

Provider Name: _____ Group Number: _____

Member ID #: _____ Policy Holder Date of Birth: ____/____/____

Policy Holder Name: _____

Employer Name: _____

Secondary Insurance *(if applicable)*

Provider Name: _____ Group Number: _____

Member ID #: _____ Policy Holder Date of Birth: ____/____/____

Policy Holder Name: _____ Employer Name: _____

Family Information

Other family members seen at this practice: _____

How Did You Hear About Us?

☐ Google ☐ Insurance Provider ☐ Friend / Family ☐ Social Media ☐ Existing Patient
☐ Other: _____

Patient Experience

What matters most to you about your dental care?

Do you have any concerns or goals for your smile?

Additional Wellness Services

☐ I am interested in learning about optional wellness services that may support my oral and overall health and would like additional information.

Acknowledgement & Consent

I confirm that the information provided is accurate to the best of my knowledge. I understand that I am responsible for payment of services rendered and consent to be contacted regarding appointments and care.

Patient Name:_____Signature: _____

Date: ____/____/____