

Dr. Alice P. Moran, DMD

Welcome and 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.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Widowed Separated Partnered

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____

Employer _____ Work Phone _____ SS#/ SIN _____

Email _____ (For Internal Use Only)

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 that you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card Care Credit

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/ SIN _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Insurance Company _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to patient _____

Birthdate _____ SS#/ SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Insurance Company _____ Group# _____ Policy/ID# _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____