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

Patient Information

First Name: ______________ Last Name: ______________ Middle Initial: ______

Address: ______________ Preferred Name: ______________

City: ______________ State: __________ Zip: __________

Home Phone: __________ Work Phone: __________ Ext:______ Cellular: __________

Marital Status: O Single O Married O Divorced O Separated O Widowed

Sex: O Male O Female

Birth Date: __________ Age: ________ Soc. Sec: ______________

Email:______________ O I would like to receive correspondence via email

Employer: ______________ Occupation: ______________

Spouse: ______________

Children's Names: ______________

Is there anyone we may thank for referring you to our offices? ______________

Primary Dental Insurance Information

Name of Insured:______________ Relationship to Patient: O Self O Spouse O Child O Other

Insured Soc. Sec. ______________ Insured Birth Date: ______________

Employer: ______________

Ins. Company: ______________ Ins. Phone#:______________

Ins. Co. Address: ______________

Group #:______________ ID #: ______________

Payment Options

To help keep the cost of dentistry down and to continue to provide quality care to our valued patients, we now expect payment in full on your first visit. Subsequent visit balances not covered by your insurance can be paid using the following options:

Please (✓) below the option(s) most convenient for you to pay on your account balance.

- O Cash
- O Check
- O Visa, MC, Amex, or Discover
- O Easy monthly payment program (see insurance coordinator for application)

______________________ ______________________

Signature of Responsible Party Date

1441 Sachem Place, Suite 1 · Charlottesville, VA 22901 · 434.973.2224 · fax 434.973.2361 · HillcrestDentalVA.com