We are pleased to welcome you to Powers Dental Group
Please take a few minutes to fill out this form as completely as you can.
If you have any questions, we are glad to assist you.

Patient Information **Today's Date: _____**

Name: _____
Last First Middle Initial Preferred Name

Address: _____
Street City State Zip Code

SSN: _____ Date of Birth_____ Gender: □ M □ F

Home Phone #: _____ Cell #:_____ Work #:_____

(Please circle your preferred contact number above) Employer:_____

Email:_____

If patient is under 18 years, please also complete the following guardian information:

Guardian Name: _____
Last First Middle Initial Preferred Name

Date of Birth_____ Gender: □ M □ F Email:_____

Home Phone #: _____ Cell #:_____ Work #:_____

Insurance Policy 1 *Relationship to Patient*: □ Self □ Spouse □ Parent □ Child □ Other_____

Subscriber name:_____
Last First Middle Initial

Subscriber Date of Birth: _____ Subscriber SSN:_____ Subscriber ID #: _____

Insurance Company: _____ Insurance Telephone No.: _____

Employer: _____Group Name: _____Group #:_____

Insurance Policy 2 *Relationship to Patient*: □ Self □ Spouse □ Parent □ Child □ Other_____

Subscriber name:_____
Last First Middle Initial

Subscriber Date of Birth: _____ Subscriber SSN:_____ Subscriber ID #: _____

Insurance Company: _____ Insurance Telephone No.: _____

Employer: _____Group Name: _____Group #:_____

How did you hear about us? (If someone referred you, please provide their name so we can thank them!)

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