

WELCOME!



Troy E. Aland, DDS

Aland Family Dentistry

Today's Date _____

PATIENT INFORMATION (CONFIDENTIAL)

Birthdate _____ Age _____

Name _____ M / F Social Security _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Would you like to receive your statements & receipts via email? Yes No
If Yes, please note that you will NOT receive paper statements in the mail.

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Spouse/Parent _____ Emergency Contact _____ Phone _____

Employer (PT) _____ Phone _____

Were you referred to our office? If so, by whom: _____

RESPONSIBLE PARTY: *If different than insured party for MINOR ONLY*

Name Of Person Responsible For This Account _____ Relationship To Patient _____

Address _____ City _____ State _____ Zip _____

Driver's Lic. # _____ Birthdate _____ S.S. # _____ Phone _____

INSURANCE INFORMATION:

Name Of Insured Party If Different Than Patient _____ Relationship To Patient _____

Birthdate Of Insured Party _____ S.S. # _____ Work Phone _____

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Primary Policy Holder's Employer _____ Phone _____

Dental Insurance Company _____ Phone _____

Dental Insurance Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? IF "YES", PLEASE COMPLETE THE FOLLOWING:

Name Of Insured Party _____ Relationship To Patient _____

Birthdate Of Insured Party _____ S.S. # _____ Work Phone _____

Name Of Employer _____ Phone _____

Dental Insurance Company _____ Phone _____

Dental Insurance Address _____ City _____ State _____ Zip _____

PLEASE COMPLETE BACK SECTION

