



ROBERT R. WATTS | DDS |

Cosmetic and Family Dentistry  
Dental Sleep Disorder Therapy

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.

# Welcome

## Patient Information (CONFIDENTIAL)

Soc. Sec. # \_\_\_\_\_  
 Date \_\_\_\_\_  
 Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
 If Student, Name of School / College \_\_\_\_\_ State \_\_\_\_\_  
 Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse or Parent'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 \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN# \_\_\_\_\_  
 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 you prefer. Payment in full at each appointment.  
 Cash  Personal Check  Credit Card  VISA  Mastercard  
 I wish to discuss the office's payment policy

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy / ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 How Much Is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

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

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy / ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 How Much Is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_