WELCOME

THANK YOU FOR CHOOSING HANCOCK DENTAL!

Patient Information

Please complete this form in ink. (Please Print)

Name_____ Birth date_____ Phone_____
First MI Last

Address_____ City_____ State_____ Zip_____

Social Security #____-____-____ Sex M____ F____ Single Married Divorced Separated

E-mail _____ Cell Phone _____

How did you hear about our office? (circle all that apply)

*Referral from an existing patient? (whom may we thank)_____

*Phone book *Location *TV commercial *Radio Ad *Pharmacy Bag

*Promotional Banner *Website *Facebook *Business Card

Responsible Party

Name of person responsible for this account?_____

Address_____ City_____ State____ Zip_____ Phone_____

Social Security #____-____-____ Sex M____F____ Single Married Divorced Separated

For your convenience we offer the following methods of payment.
Please check the option you prefer. Payment in full is due at the time of service

____Cash ____Personal Check ____Credit Card

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # ____-____-____

Employer_____ Work Phone _____

Address of Employer _____ City_____ State _____ Zip _____

Insurance Company_____ Group # _____

Insurance Co. Address _____ City _____ State_____ Zip _____

Do you have any additional Insurance? Yes____ No____ If yes, complete the following:

Second Insurances

Name of Insured_____ Relationship to Patient _____

Birth Date _____ Social Security # ____-____-____

Employer_____ Work Phone_____

Address of Employer _____City_____ State____ Zip_____

Insurance Company _____ Group # _____

Insurance Co. Address_____ City_____ State _____ Zip _____