Oceanside Family Dental, PC
421 Lafayette Road
Hampton, NH 03842
Phone: 603-926-1551 **Fax:** 603-926-1563
www.oceansidedental.net

WELCOME

Appointment: ___/___/___ at ________

Received in office: ___/___/___

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

First Name:	Middle:	Last Name:	Date:
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
☐ Home Phone:	☐ Work Phone:	☐ Cell Phone:	
Please check preferred daytime phone / email			
☐ Email Address:	Birth date:	Age:	SS#:
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
You or your parent's employer:	Occupation:		
Business Address:	City:	State:	Zip:
Person to contact in case of emergency:	Relationship:	Phone:	
Name of closest relative not living with you:	Relationship:	Phone:	
Whom may we thank for referring you to us?:			

Responsible Party

Name of person responsible for this account:			Phone:
Relationship to patient:	Employer:		Phone:
Business Address:	City:	State:	Zip:

Dental Benefits

Name of insured:		Relationship to patient:	
Birth date:	SS#:	Date of employment:	
Name of employer:			Phone:
Business Address:	City:	State:	Zip:
Insurance Co.:	Group#:	Employer#:	
Business Address:	City:	State:	Zip:
Deductible:	How much of annual benefit used?	Maximum annual benefit:	

Secondary Insurance

Name of insured:		Relationship to patient:	
Birth date:	SS#:	Date of employment:	
Name of employer:			Phone:
Business Address:	City:	State:	Zip:
Insurance Co.:	Group#:	Employer#:	
Business Address:	City:	State:	Zip:
Deductible:	How much of annual benefit used?	Maximum annual benefit:	