



# Wellness BioDentistry

Whole Health Implant Dentistry

Dr. Jordan Baker, DDS

Patient name: _____	<b>DENTAL INSURANCE</b>
Prefer to be called: _____	PRIMARY DENTAL INSURANCE
<input type="checkbox"/> Male <input type="checkbox"/> Female	Insurance Co. Name: _____
Date of birth: _____	Policyholder's name: _____
Mailing address: _____	Policyholder's birthdate: _____
City _____ State _____ Zip _____	Policyholder's ID# _____
Primary phone: _____	Policyholder's SSN: _____
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Group # _____
Other phone: _____	<b>SECONDARY DENTAL INSURANCE</b>
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Insurance Co. Name: _____
Email: _____	Policyholder's name: _____
How would you prefer we contact you?	Policyholder's birthdate: _____
Mark all that apply:	Policyholder's ID# _____
<input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Phone call <input type="checkbox"/> Postcard	<b>OTHER FAMILY MEMBERS SEEN BY US</b>
	_____
	_____
<b>SPOUSE OR PATIENT INFORMATION</b>	
Name: _____	
Primary phone: _____	<b>HOW CAN WE BE YOUR IDEAL DENTAL OFFICE?</b>
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	_____
Other phone: _____	_____
<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	_____
<b>EMERGENCY CONTACT IF OTHER THAN SPOUSE OR PARENT</b>	
Name: _____	<b>AUTHORIZATION</b> The information I have given today is correct to the best of my knowledge. I authorize payment directly to Wellness BioDentistry of the group insurance benefits otherwise payable by me. I understand that I am responsible for all costs of treatment, and that it is my responsibility to inform this office of any changes in my medical or insurance status. I authorize Dr. Baker and the associates or employees of Wellness BioDentistry to perform any dental services that I may need during diagnosis and treatment with my informed consent.
Relationship to you: _____	
Telephone: _____	
_____	
<b>HOW DID YOU HEAR ABOUT US?</b>	
Who may we thank for referring you? _____	
_____	
<input type="checkbox"/> Internet search <input type="checkbox"/> Our website	
<input type="checkbox"/> Another website _____	Signature: _____
<input type="checkbox"/> Other _____	Date: _____