



Wellness BioDentistry

Whole Health Implant Dentistry

Dr. Jordan Baker, DDS

Patient name: _____		DENTAL INSURANCE	
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: _____		SECONDARY DENTAL INSURANCE	
<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		OTHER FAMILY MEMBERS SEEN BY US	
SPOUSE OR PATIENT INFORMATION		_____	
Name: _____		_____	
Primary phone: _____		HOW CAN WE BE YOUR IDEAL DENTAL OFFICE?	
<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		_____	
EMERGENCY CONTACT IF OTHER THAN SPOUSE OR PARENT		AUTHORIZATION	
Name: _____		<p>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.</p>	
Relationship to you: _____			
Telephone: _____			

HOW DID YOU HEAR ABOUT US?		Signature: _____	
Who may we thank for referring you? _____		Date: _____	
<input type="checkbox"/> Internet search <input type="checkbox"/> Our website		_____	
<input type="checkbox"/> Another website _____		_____	
<input type="checkbox"/> Other _____		_____	