Boucher Family Dentistry, PLLC

Welcome

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. If you have any questions, or need assistance, please ask us — we will be happy to help.

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse or Parent / Guardian's Name _____

Whom may we thank for referring you? _____

How long since your last dental exam and cleaning? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Birthdate _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# / SIN _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone No. _____

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

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# / SIN _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone No. _____