spring dental group ltd.
5440 Spring St. Racine, WI 53406 Phone (262) 886-9440

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

Patient # _____
Social Sec. # _____
Date _____
Email Address _____
Cell Phone _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
How would you like us to address you? _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Patient is a Student Name of School/College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Relative to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Marital Status _____ Home Phone _____
City _____ State _____ Zip _____ Birthdate _____
Employer _____ Work Phone _____
Social Security # _____ E-mail _____ Fax# _____
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____
Insurance Company Address _____ City _____ State _____ Zip _____

NOTE: If you receive Direct Reimbursement from your insurance carrier, payment at time of service is expected. The patient portion of charges are also due at time of service.

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

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____
Insurance Company Address _____ City _____ State _____ Zip _____