



**NORTH APPLETON**  
DENTISTRY LLC

3521 COMMERCE CT – APPLETON, WI 54911 – (920)-734-7730

# WELCOME TO OUR PRACTICE

Patient Name \_\_\_\_\_  
(Last Name) (First Name) (MI)

Preferred Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: Male / Female      Family Status: Single / Married / Minor

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone Numbers: \_\_\_\_\_  
(Home) (Cell) (Work)

Email Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

***If you have dental insurance through a guardian or spouse, please fill out the Responsible Party Information below. You will be asked to present a valid photo ID and insurance card if applicable.***

## Responsible Party Information

**This section needs to be filled out if the patient is under the age of 18 and/or insurance is through a guardian/spouse.**

Name \_\_\_\_\_  
(Last Name) (First Name) (MI)

Date of Birth: \_\_\_\_\_      Gender: Male / Female      Family Status: Single / Married / Minor

Social Security #: \_\_\_\_\_      Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone Numbers: \_\_\_\_\_  
(Home) (Cell) (Work)