BFD
Buffalo Family Dentistry
106 Center Drive • Buffalo, MN 55313
(763) 682-6885 Fax: (763) 682-4534

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

PATIENT INFORMATION (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____

Name _____ Birthdate _____ Home phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell phone _____
Would you like to be contacted via text message? ☐ Yes ☐ No Email? ☐ Yes ☐ No
Check appropriate box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Full time ☐ Part time
If student, name of school/college _____ City _____ State _____
Patient or parent/guardian's employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Spouse or parent/guardian's name _____ Employer _____ Work phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Email _____ Cell phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work phone _____ SS#/SIN _____
Is this person currently a patient in our office: ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Check the option you prefer. Payment in full is required at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ MasterCard ☐ I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birthdate _____ SS#/SIN _____ Date employed _____
Name of employer _____ Union or Local # _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Policy ID # _____
Insurance company address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS#/SIN _____ Date employed _____
Name of employer _____ Union or Local # _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Policy ID # _____
Insurance company address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____