Kenneth P McInnis, DMD
1791 NW 173rd Ave. Ste.130
Beaverton, Oregon 97006

Phone 503 640-0395

Welcome to Our Practice!

Thank you for selecting our dental healthcare team! We promise to constantly strive to provide you with the best possible dental care.

Patient Information

Patient Name ______________________________ Name Preference _________________
Address _____________________________City ______________ State___ Zip _______
SSN _________________________________ Date of Birth _________________
Employer ___________________________________ Home Phone ___________________
Address ____________________________________ Cell Phone _____________________
Email ______________________________________ Work Phone ___________________
Emergency Contact________________________ Relationship_______ Phone ___________
Other family members who are patients in our office _______________________________
How did you hear about our office? _______________________________

Responsible Party Information (If different than above.)

Name __________________________________ Relationship to Patient ______________
Address ______________________________City _____________ State ___ Zip _______
Home Phone __________________________________ Date of Birth ________________
Employer _______________________________Social Security # ____________________
Address ___________________________________ Phone ________________________

Dental Insurance Information

Dental Insurance Co. _______________________________ Effective Date _____________
Address ______________________________ City _____________ State ___ Zip ________
Name of Policy Holder _____________________________Date of Birth ______________
ID or SSN __________________________ Group # ________________________
Annual benefit $ ______ Deductible $ _______ Amount already used this year $ _______

Secondary Insurance Co. ___________________________ Effective Date ____________
Address ______________________________ City ______________ State ___ Zip ______
Name of Policy Holder ______________________________ Date of Birth ______________
ID or SSN __________________________ Group # ________________________
Annual benefit $ _______ Deductible $ ______ Amount already used this year $ _______

I hereby authorize payment of benefits directly to the provider and the release of all necessary information to the insurance carrier.

Signature of the Insured __________________________________ Date ______________