

Patient Information (CONFIDENTIAL)

Date _____

SS# _____

Name _____ Birth Date _____

Home Phone _____

Cell Phone _____

Address _____ City _____ State _____ Zip _____

Please circle: Male / Female Minor / Single / Married / Divorced / Widowed

If Student, Name of School/ College _____ City _____ State _____

Patient's Employer _____ Work Phone _____

Spouse or Parent's Name _____ Employer _____

E-mail address _____

Preferred method of contact? Please Circle: Cell Phone / Home Phone / E-mail

Person to contact in case of emergency _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party (if patient is a minor)

Person responsible for this account _____ Relationship to Patient _____

Address _____ Phone _____

Social Security # _____ Work Phone _____ Birth Date _____

Employer _____

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Social Security # _____ Birth Date _____

Name of Employer _____ Insurance Company _____

Policy ID # _____ Insurance Company Phone _____

Secondary Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Social Security # _____ Birth Date _____

Name of Employer _____ Insurance Company _____

Policy ID # _____ Insurance Company Phone _____

PLEASE COMPLETE REVERSE SIDE