Patient Information

Today's Date_____ Patient's Birthdate_____ Social Security # ____-____-____ DL #_____

Patient's Name_____
Last First Middle Name you prefer to be called

Physical Address_____ E-mail address_____
Street City State Zip Code

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Employer_____ Occupation_____ No. of Years Employed_____If Patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office? _____

Primary Emergency Contact _____Phone_____

Secondary Emergency Contact _____Phone_____

Account Information

(Person ultimately responsible for account)

Name_____ Relationship to Patient_____
Last First Middle

Billing Address_____
Street City State Zip Code

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Occupation_____

Birthdate_____ Social Security #_____-_____-_____

Dental Insurance Information

Primary Dental Insurance:

Insured's Name_____ Relationship to Patient_____ Insured's Employer_____

Insured's Social Sec. #_____-____-_____ Insured's Birthdate_____ Insurance Company Name_____

Group #_____ Ins. Co. Phone #_____Insurance Company Address_____

Secondary Dental Insurance:

Insured's Name_____ Relationship to Patient_____ Insured's Employer_____

Insured's Social Sec. #_____-____-_____ Insured's Birthdate_____ Insurance Company Name_____

Group #_____ Ins. Co. Phone #_____Insurance Company Address_____

Signature: _____

Date: _____