CONFIDENTIAL

PATIENT INFORMATION **DATE**____________________

(PLEASE PRINT)

NAME____ DATE OF BIRTH _______________ M ___ F ___

ADDRESS____

CITY____ ST____________________ ZIP _______________

HOME PHONE______________________________ CELL PHONE ________________________________

SS# _________-_________-_____________ DRIVER'S LICENSE# ________________________________

(CHECK ONE) MINOR _____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

PATIENT'S OR PARENTS EMPLOYER ____

BUSINESS ADDRESS ____

CITY____ ST____________________ ZIP _______________

WORK PHONE____________________________ EMAIL ______________________________________

SPOUSE/PARENT'S NAME ____

EMPLOYER____ WORK PHONE _______________

IF A STUDENT, NAME OF SCHOOL/COLLEGE ____

PERSON TO CONTACT IN CASE OF EMERGENCY ____

HOME PHONE__________________________ WORK PHONE/CELL PHONE _____________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

RESPONSIBLE PARTY (IF DIFFERENT THAN ABOVE) ____

NAME____________________________________ RELATION TO PATIENT ___________________________

ADDRESS____ HOME PHONE ______________________

CITY____ ST____________________ ZIP _______________

DATE OF BIRTH______________ SS# _____-_____-______ DRIVER'S LICENSE# ____________________

EMPLOYER____ WORK PHONE ______________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES_____ NO _____

INSURANCE INFORMATION

NAME OF INSURED____ DATE OF BIRTH ________________

SS# _________-_________-_____________ RELATIONSHIP TO PATIENT ______________________________

NAME & ADDRESS OF EMPLOYER ____

___________________________________ CITY______________ ST__________________ ZIP____________

INSURANCE COMPANY____ GROUP# ___________________

ADDRESS____ CITY ___________________________

ST__________________ ZIP ____________ PHONE NUMBER _____________________________________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? YES_____ NO_____

NAME OF INSURED____ DATE OF BIRTH ________________

SS# _________-_________-_____________ RELATIONSHIP TO PATIENT ______________________________

NAME & ADDRESS OF EMPLOYER ____

___________________________________ CITY______________ ST__________________ ZIP____________

INSURANCE COMPANY____ GROUP# ___________________

ADDRESS____ CITY ___________________________

ST__________________ ZIP ______________ PHONE NUMBER ___________________________________

APPROXIMATE DATE OF LAST DENTAL VISIT ____

NAME OF LAST DENTIST____