Patient Information

Date: ________________________ E-Mail Address ____________________________________

Patient's Name: ____
Last First Middle

Address: ____
Street City State Zip

Home/Cell Phone: ____________________Birth Date: ____________________ SS#: ____________________

If patient is minor, give parent or guardian's name: ____

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

Responsible Party Information

Name: ____
Last First Middle Marital Status

Residence: ____
Street City State Zip

Mailing Address: ____
Street City State Zip

How long at this address? __________ Home Phone: ____________________ Work Phone: ________________

Previous address (if less than 3 years) ____

SS#: ________________________ Birth Date: ______________________ Relationship to Patient: ___________

Employer: ____________________Occupation: ______________________ No. Years Employed: ____________

Spouse's Name: ____ Relationship to Patient: ____________

Employer: ____________________ Occupation: ______________________ No. Years Employed: ___________

SS#: _________________________ Birth Date: ______________________ Work Phone: ___________________

Dental Insurance Information

Primary Insured's Name: ____Insured's SS#: _______________

Insurance Co: ____ Group #: __________________

Insurance Co. Address: ____

Insured's Employer: ____

Do you have dual coverage? ☐ yes ☐ no If yes: ____

Secondary Insured's Name: ____Insured's SS#: _________________

Insurance Co: ____ Group #: __________________

Insurance Co. Address: ____

Emergency Information

Name of nearest relative not living with you ____

Complete Address: ____

Phone Number: _________________________

I authorize treatment for the above-named patient.

Signature ____ **Over**