PATIENT INFORMATION

Date____________________

Patient's name ____

Last First Middle

Address____

Street City Zip

Home Phone_______________________ Birth date_______________ Social Security #___________________

If patient is a minor, give parent's or guardian's name ______________________________________

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

RESPONSIBLE PARTY INFORMATION

Name ____

Last First Middle

Mailing Address ____

Street City Zip

Home phone________________________ Work phone______________Cell/other phone____________________

Email address ____

Previous Address (If less than 3 years) ____

Social Security #_______________________ Birth date_______________ Relationship to Patient __________

Employer_______________________________________ Occupation ___________________________________

Spouse's Name____ Relationship to Patient ___________

Employer_______________________________________ Occupation ___________________________________

Social Security # _________________________ Birth date _______________Work Phone________________

DENTAL INSURANCE INFORMATION

Insured's Name____ Insured's Social Security # __________

Insurance Company__________________________ Group No._________________ Local No. ____________

Insurance Co. Address____ Phone No. ___________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name____ Insured's Social Security # _____________

Insurance Company__________________________ Group No._________________ Local No. ____________

Insurance Co. Address____ Phone No. ___________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Complete address____

Street City Zip

Phone ____

Signature (Parent's signature if minor) ____

Updates (date & initial) ____