WE WOULD LIKE TO GET TO KNOW YOU BETTER!

PATIENT INFORMATION

PATIENT'S NAME: Last __________________________ First ________________________ MI ____ SEX : M F BIRTHDATE _____________ AGE _____

SSN _____________________ If Patient is a minor, give Parent's or Guardian's Name ___________________________ TODAY'S DATE ______________

ADDRESS Street ____ City _______________________ State ______________Zip ______________

HOME PHONE _______________________________ WORK PHONE ___________________________ CELL PHONE ____________________________

E-MAIL _______________________________ HOW DID YOU HEAR ABOUT US ______________________ REASON FOR THIS VISIT_________________

RESPONSIBLE PARTY INFORMATION

NAME Last ___________________________________ First _______________________________ MI ______ MARITAL STATUS ________________

ADDRESS Street ____ City _______________________ State ______________Zip ______________

HOME PHONE _______________________________ WORK PHONE ___________________________ CELL PHONE ____________________________

SSN ______________________ BIRTHDATE ____________________ RELATION TO PATIENT ________________ EMAIL __________________________

EMPLOYER ____ OCCUPATION ___________________________ NO OF YEARS ____________________

RESPONSIBLE PARTY'S SPOUSE

NAME ____

EMPLOYER ______________________ OCC___________________

SSN _______________________ BIRTHDATE ___________________

HOME PH ___________________ CELL PH ____________________

WORK PH _________________ EMAIL ______________________

EMERGENCY INFORMATION: RELATIVE

NAME ____

ADDRESS____

HOME PHONE __________________ CELL PHONE____________________

WORK PH ______________________ RELATIONSHIP _________________

DENTAL INSURANCE INFORMATION (PRIMARY)

Insured's Name ____

Insurance Co. ____

Insured's Employer ____

Insured's SSN ______________________ Birthdate _____________

Insured's ID #_________________________Grp # ____________

If you have double dental insurance coverage, complete this for the second coverage

Insured's Name ____

Insurance Co ____

Insured's Employer ____

Insured's SSN________________________ Birthdate ________________

Insured's ID # _____________________________Grp # _______________