PATIENT INFORMATION

Legal Name ____________________ Preferred Name ____________________ Date of Birth ____________
(Please Check Your Answer) Sex: ___ Male ___ Female Marital Status: ___Single ___Married ___Separated ___Divorced ___ Widowed
Mailing Address ____________________ City ____________________ State ____________
Home Phone ____________ Cell Phone ____________ E-Mail Address ____________________
Employer ____________________ Work Phone ____________ Ext ________
Employer Address ____________________ City ____________________ State ____________
Social Security Number ____________________ How did you hear about our practice? ____________
In case of emergency, who should be notified?
1) Name ____________ Phone ____________ 2) Name ____________ Phone ____________
Names of Family members who are patients here: ____________________

PERSON RESPONSIBLE FOR THIS ACCOUNT

IF DIFFERENT FROM ABOVE
(If patient is a child, please complete the next 2 sections for the child's parents)

Name ____________________ Relationship to Patient ____________ Date of Birth ____________
Home Address (if different from above) ____________________ Home Phone ____________
Employer ____________________ Social Security Number ____________
Business Address ____________________ Work Phone ____________

PATIENT'S SPOUSE OR OTHER PARENT

Name ____________________ Relationship to Patient ____________ Birth Date ____________
Home Address (if different from above) ____________________ Home Phone ____________
Employer ____________________ Social Security Number ____________
Business Address ____________________ Work Phone ____________

INSURANCE INFORMATION

Primary Dental Insurance

Dental Insurance ___ Yes ___ No Effective Date ____________
Subscriber's Name ____________________
Subscriber's Birth Date ____________________
Subscriber's Employer ____________________
Insurance Company ____________________
Ins Co Address ____________________
Phone No. ____________________
Group No. ____________ ID No. ____________

Secondary Dental Insurance

Dental Insurance ___ Yes ___ No Effective Date ____________
Subscriber's Name ____________________
Subscriber's Birth Date ____________________
Subscriber's Employer ____________________
Insurance Company ____________________
Ins Co Address ____________________
Phone No. ____________________
Group No. ____________ ID No. ____________

Medical Insurance

Medical Insurance _____ Yes _____ No Effective Date ____________
Subscriber's Name ____________________ Subscriber's Date of Birth ____________
Subscriber's Employer ____________________
Name of Insurance Company ____________________
Insurance Company Address ____________________
Insurance Company Phone No. ____________ Group No. ____________ ID No. ____________