Date_____

Patient Information (confidential)

Name_____Birthdate_____Home phone_____
Preferred name_____S.S.#_____cell phone_____
Email address_____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Address_____City_____State_____Zip_____
Employer_____Job title_____Work phone_____
Spouse or parent's name_____Phone_____
Person to contact in case of emergency_____Phone_____
Physician_____Phone_____
Dentist_____

Responsible party

Name of person responsible for this account_____Relationship to patient_____
Address_____City_____State_____Zip_____
Birthdate_____Home phone_____S.S.#_____
Employer_____Work phone_____
Is this person currently a patient in our office? ____Yes ____No

Dental insurance information

Name of insured_____Relationship to patient_____
Birthdate_____S.S.#_____Work phone_____
Name of employer_____Union or local#_____
Address of employer_____City_____State_____Zip_____
Insurance company_____Group#_____Policy/ID#_____
Ins. Co. address_____City_____State_____Zip_____

Do you have any additional dental insurance? ___Yes ___No

Name of insured_____Relationship to patient_____
Birthdate_____S.S.#_____Work phone_____Union or local#_____
Name of employer_____
Address of employer_____City_____State_____Zip_____
Insurance company_____Group#_____Policy/ID#_____
Ins.Co.address_____City_____State_____Zip_____