

PATIENT INFORMATION

Date _____
Patient's Name _____ Last First Middle
Home Phone _____ Birthdate _____ 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 Marital Status
Residence _____ Street City State Zip
Mailing Address _____ Street City State Zip
How long at this address _____ Home Ph. _____ Work Ph. _____ Cell Ph. _____
E-mail Address: _____
Previous Address (if less than 3 yrs.) _____ Street City State Zip
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Last First Middle Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Ph. _____ Cell Ph. _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes:
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____
I hereby authorize payment directly to the Dental Office of the insurance benefits payable to me. I understand that I am responsible for all costs of dental treatment. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature, if minor) _____

Updates (Date & Initial) _____