

Patient Information

A B C

Date _____ Email _____

Patient's Name _____ M / F
Last First Middle Preferred First Name Sex

Address _____
Street City State Zip

Home Phone () _____ Birthdate _____ Age _____ Social Security # _____

Patient's Dentist _____ Referred By _____ Patient's Physician _____

Other family members in treatment _____

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 Phone () _____ Work Phone () _____

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 _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone () _____

Dental Insurance Information

Policy Holders
 Name _____ Birth date _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Employer _____ Ins. Co. Phone # () _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Birth date _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____ Ins. Co. Phone # () _____

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) _____

