

Patient Information

(PLEASE PRINT)

DATE _____

NAME _____
FIRST MI LAST PREFERRED NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ HOME PHONE _____

SS # _____ CELL PHONE _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

Responsible Party

"Please complete this section if the person responsible for this account is someone other than the patient."

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

Dental Insurance Information

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ CONTRACT ID # _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS # _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____