

PATIENT INFORMATION

DATE

Patient's Name _____ Male ___ Female ___
Last First MI Preferred Name

Address _____
Street City State Zip Code

Home Phone _____ Work Phone _____ Cell# _____

Patient's SSN _____ Birthday _____ E-mail _____

Marital Status Mr. Mrs. Ms. If a minor, give parent's or guardian's name _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____

Address _____ Birthday _____
Street City State Zip

Home Phone _____ Work Phone _____ SSN _____ Drivers License No. _____

Employer _____ Occupation _____

EMPLOYEE BENEFIT INFORMATION

Insured's Name _____ Insured's SSN _____
Last First MI

Insured's Birthday _____

Dental Insurance Company _____ Group No. _____ ID No. _____

Insurance Company Address _____
Street City State Zip

Insured's Employer _____ Employer's Address _____
Street City State

Employer's Phone _____ Date of Employment _____ Effective Date of Insurance _____

EMERGENCY NOTIFICATION INFORMATION

In case of emergency, who should be notified?

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

To the best of my knowledge all the preceding answers are true and correct. I will inform your office of any changes at the next appointment.

Signature of Patient or Guardian _____

_____ Date