Date:_____

Patient Information

Patient's First Name_____ Middle____ Last_____ Preferred Name (_____)

Home Address_____City_____ State_____ Zip_____

Phone Number Home _____Work _____ Cell _____

Date of Birth_____ Age _____ Sex:__M__F Social Security# _____ Marital Status_____

Employer_____Address_____

If Student Name and City of School_____

Emergency Contact_____Phone Number_____

Medical Doctor_____Phone Number_____

Previous Dentist_____Phone Number_____

Who May We Thank for Referring You to Our Office_____

Responsible Party Information

Please fill out **ONLY** if it's different then the patient information above.

Responsible Party's First Name_____Middle_____Last_____

Address_____City_____State_____Zip_____

Phone Number Home_____Work_____Cell_____

Employer_____Address_____

Social Security#_____DOB_____Sex_____Relationship to Patient_____

Insurance Information

Insured's First Name_____Middle_____Last Name_____

Address_____City_____State_____Zip_____

Social Security #_____DOB_____Relationship_____

Employer _____Address_____Telephone Number_____

Insurance Name_____Group#_____

Address_____City_____State_____Zip_____

Insurance Telephone Number_____

Signature_____

(**ADULT** patient or legal guardian only)