

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)

