

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)

