PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ BIRTH DATE_____
FIRST MI LAST

SS#_____-_____-_____ P.O. BOX _____ CITY_____ STATE_____ ZIP_____

PHYSICAL ADDRESS _____ CITY_____ STATE_____ ZIP_____

HOME PHONE ( )_____-_____ CELL PHONE ( )_____-_____
EMAIL ADDRESS_____
CAN WE CONTACT YOU BY TEXT MESSAGE OR EMAIL FOR APPOINTMENT AND RECALL REMINDERS YES / NO

CIRCLE APPROPRIATE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

STUDENT: YES / NO FULL TIME / PART TIME
NAME OF SCHOOL_____ CITY_____ STATE_____
PATIENT'S EMPLOYER _____ DEPARTMENT_____
CITY _____ STATE_____ ZIP_____ PHONE _____

IF MARRIED, NAME OF SPOUSE_____ EMPLOYER_____
CELL PHONE _____ WORK PHONE _____

IF MINOR, NAME OF PARENT(S) OR GUARDIAN Child Lives With: FATHER MOTHER BOTH PARENTS GUARDIAN OTHER

MOTHER'S NAME_____ PHONE_____

FATHER'S NAME _____ PHONE_____

PERSON TO CONTACT IN CASE OF EMERGENCY _____
PHONE _____ RELATIONSHIP TO THE PATIENT_____

HOW DID YOU HEAR ABOUT US? _____

RESPONSIBLE PARTY INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____
BIRTH DATE_____ SS#_____-_____-_____ DRIVER'S LICENSE #_____ ST_____
MAILING ADDRESS_____ PHONE_____
EMPLOYER_____ WORK PHONE_____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE YES / NO

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE
NAME OF INSURED_____ SS#_____-_____-_____ BIRTH DATE_____
EMPLOYER_____ ADDRESS_____ PHONE_____
INSURANCE COMPANY_____ PHONE_____
POLICY ID#_____ GROUP#_____

SECONDARY DENTAL INSURANCE
NAME OF INSURED_____ SS#_____-_____-_____ BIRTH DATE_____
EMPLOYER_____ ADDRESS_____ PHONE_____
INSURANCE COMPANY_____ PHONE_____
POLICY ID#_____ GROUP#_____

REV10/09