Patient Information

Date_____ Sex: M ☐ F ☐

Patient's name _____
First M.I. Last Common Name

Address _____
Street City Zip

Home Phone_____ Birthdate_____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

General Dentist_____ Phone_____ Physician_____

Whom may we thank for referring you to our office_____

Responsible Party Information

Title_____ Name _____
First MI Last

Address _____
Street City Zip

No. years at this address?_____ Home phone_____ Work phone_____

Previous Address (If less than 3 years) _____

E-mail address_____ Cell phone _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed_____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed_____

Social Security # _____ Birthdate_____ Work Phone _____

Dental Insurance Information

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Dual coverage? If so: Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Emergency and Other Information

Name of nearest relative not living with you_____Phone_____

Full address _____
Street City State Zip

Patient's School_____ Who primarily brings patient to appointments?_____

Siblings' Names and Ages_____

**I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____