PATIENT INFORMATION (PLEASE PRINT)

Title: _____ First Name: _____ MI: _____ Last Name: _____

Birthdate: _____ Soc. Sec.: _____ Gender: ◯ Male ◯ Female

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Cell: _____ Work: _____ Ext: _____

Home: _____ Email: _____

Employer: _____ Phone: _____ Occupation: _____

Referred By: _____ General Dentist: _____

Have you been seen in this practice before today? ◯ YES ◯ NO

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: _____ Last Name: _____

Relationship to Patient: ◯ Patient ◯ Spouse ◯ Child ◯ Other Please Specify: _____

Birthdate: _____ Soc. Sec.: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Cell: _____ Work: _____ Ext: _____

Home: _____ Email: _____

DENTAL INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Ins. Co. _____	Ins. Co. _____
Group #: _____ Phone: _____	Group #: _____ Phone: _____
Employer: _____	Employer: _____
Employee (if other than patient)	Employee (if other than patient)
Name: _____	Name: _____
Birthdate: _____ Soc. Sec.: _____	Birthdate: _____ Soc. Sec.: _____
Subscriber #: _____ Sex: ◯ Male ◯ Female	Subscriber #: _____ Sex: ◯ Male ◯ Female

_____ _____

Patient Signature (OR signature of parent or guardian if patient is a minor) Date