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Patient Information

Please complete this form in ink and print your answers.
If you have any *questions, please do not hesitate to ask one of our staff.*

Name _____ Date _____
First Name MI Last Name

Address _____

City _____ State _____ Zip _____

Birthdate _____ □ Male □ Female Home Phone# (____) _____

Cell Phone# (____) _____ Work Phone# (____) _____

Where do you prefer to take calls: □ Home □ Cell □ Work

May we contact you by E-mail? □ Yes □ No E-mail Address _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor

Social Security # _____ Drivers License # _____ State _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Spouse's Name _____ Workplace _____

If you are a student, name of school _____ City/State _____

How did you hear about our office? _____

Who may we thank for referring you? _____

Closest relative not living with you & their phone number _____

Emergency Contact _____ Phone# (____) _____

Responsible Party *(if patient is a minor)*

Name of person financially responsible for this account _____

Relationship to patient _____ Phone # (____) _____

Address of Employer _____

City _____ State _____ Zip _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Subscriber Birthdate _____ Subscriber Social Security # _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Insurance Co. _____ Group # _____

Subscriber ID # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Company Phone # (____) _____

Do you have additional dental insurance? □ Yes □ No If yes, Please complete the following:

Insurance Co. _____ Group # _____

Subscriber ID # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Company Phone # (____) _____