Please fill out all information below as completely as possible.

Patient Information

Date ____________________ Dr. Mr. Mrs. Ms. (circle one) Male ____ Female ____

Name (last) ________________________________ (first) ______________________ (middle)______________________

Street Address ____ (city) ______________ (state) _______ (zip)_________

Home Phone _________________Work Phone ______________Cell Phone _______________Email____________________

Birthdate ________________ Social Security #_____________________Relationship to Responsible Party__________________

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

Whom may we thank for referring you to our office? ____

Responsible Party

Dr. Mr. Mrs. Ms. (circle one)

Name (last) ________________________________ (first) __________________________ (middle)_ ________________

Street Address ____ (city) __________________ (state) _____ (zip)__________

How long at this address ___________________ Home Phone ______________________ Work Phone___________________

Social Security # ____ Birthdate____________________________________

Employer ____ Occupation _________________ No. Years Employed___________

Employer's Address____

Spouse's Name (last) _______________________________ (first)__________________________ (middle)________________

Spouse's Employer ____________________________________ Occupation ________________________

Spouse's Birthdate________________________________

Insurance Information

Policyholder's Name ___________________________________S.S.# _________________Birthdate_____________________

Insurance Company __________________________________ Group # ___________________ Local #____________________

Insurance Co. Address ____ (city) ________________ (state) _____ (zip)_ ________

Employer Name ____ Relationship to Patient______________________

Are you covered by another dental plan? ☐ Yes ☐ No If yes:

Policyholder's Name _________________________________ S.S.# _________________ Birthdate_______________________

Insurance Company __________________________________ Group # ___________________ Local #____________________

Insurance Co. Address ______________________________________ (city) _________________ (state) _____ (zip)_________

Employer Name ____ Relationship to Patient_______________________

Emergency Contact

Name the nearest relative/friend not living with you ____

Complete Address _____________________________________ (city) ______________________ (state) ____ (zip)_ _________

Phone ____ Relationship to Patient_______________________________________

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