PATIENT INFORMATION (CONFIDENTIAL)

Name_________________________________Pref. Name________________ Date_________

Address___________________________ City___________________ State_____ Zip_______

Home #___________________ Work #____________________ Cell #___________________

SSN__________________ Date of Birth__________________

Circle one: Minor Single Married Divorced Widowed Separated

If college student: FT / PT Name/Address of School________________________________

Employer of Patient OR Parent/Guardian______________________ Work # ____________

Business Address___________________ City_____________ State__________ Zip________

***Emergency Contact______________________________ Phone # ______________________**

***Who referred you to our practice? ____**

Appointment confirmation via email? *Yes or No. *Email address_____________________

Appointment confirmation via text message? Yes or No Cell #_______________________

RESPONSIBLE PARTY

Name of person responsible for this account______________________________________

Relationship to patient___________________________ Birthdate______________________

Address____ Home #_______________________

Employer_______________________________________Work #_______________________

Is this person currently a patient in our office? Yes or No

DENTAL INSURANCE INFORMATION

Name of Policy Holder__________________________ Relationship_____________________

Birthdate______________ SSN / ID _______________________Work #_________________

Name of Employer____

Employer Address____

Insurance Company______________________________________ Phone #_______________

Group#______________________

Insurance Company Address_______________________________

City_________________ State_________________ Zip_________________

****I understand that I am responsible for any balance that my Insurance Company does not cover****

Signature*__________________________________ **Date_________________