Patient Information

A B C

Date_____

Patient's Name_____Birthdate_____Social Security #_____
Last First Middle

Address_____ Home Phone_____
Street City State Zip

If Patient is Minor, give parent's or guardian's name_____Cell Phone_____

General Dentist_____Phone# _____Physician_____Phone#_____

Whom may we thank for reffering you to our office?_____

If patient is full time student: School_____City_____

Responsible Party Information

Name_____Marital Status_____
Last First Middle

Residence_____Own or Rent? _____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____Work Phone_____

Previous Address (if less than 3 yrs)_____
Street City State Zip

Email Address(es)_____Cell Phone_____

Social Security #_____Birthdate_____Relationship to patient_____

Employer_____Occupation _____ No. of years employed_____

Spouse's Name_____Cell Phone_____ Work Phone_____

Social Security #_____Birthdate_____ Relationship to patient_____

Employer_____Occupation_____No. of years employed_____

Insurance Information

Insured's Name_____Insured's Employer_____Insured's Social Security #_____

Insured's Insurance Company_____Ins. Co. Phone #_____

Insurance Co. Address_____Group #_____Local #_____

Please complete the following if you have dual coverage:

Insured's Name_____Insured's Employer_____Insured's Social Security #_____

Insured's Insurance Company_____Ins. Co. Phone #_____

Insurance Co. Address_____Group #_____Local #_____

Emergency Information

Name of nearest relative not living with you_____Phone Number_____

Complete Address_____Alternate Number_____

I understand that where appropriate, credit bureau reports may be obtained. CONFIDENTIAL (for record and pretreatment evaluation)

Signature(Parent's signature if minor)_____

Updates (initials & date) _____ _____ _____ _____