PATIENT INFORMATION

Name_____ ☐ Male ☐ Female

Address_____

City_____ State_____ Zip_____ Home Phone_____

Social Security_____ Birthdate_____ Email_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Patient's or Parent's Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip____

Spouse Name_____ Employer_____ Work Phone_____

If Minor, Name of Parent / Responsible Party_____

Relation to Patient_____ Soc. Sec. #_____ Birthdate_____

Address (if different from above):_____

City_____ State_____ Zip_____ Home Phone_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of an Emergency_____ Phone_____

INSURANCE INFORMATION

If you are not covered by DENTAL Insurance, please leave blank.

Name of Insured_____ Relation to Patient_____

Soc. Sec. #_____ Birthdate_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip _____

Insurance Co._____ Group #_____ Policy / ID #_____

Ins. Co. Phone #_____

*Do You Have Additional Insurance? ☐Yes ☐ No If Yes, Complete the Following:

Name of Insured_____ Relation to Patient_____

Soc. Sec. #_____ Birthdate_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Co._____ Group #_____ Policy / ID #_____

Ins. Co. Phone #_____

X_____ _____

Signature of Patient or Parent if Minor **Date**