

Welcome

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Patient Information

Patient's Name _____ Date _____
Preferred Name _____ Sex _____
Street Address _____ Date of Birth _____
Patient's Physician Name _____ Patient's Dentist _____
Whom may we thank for referring you? _____

Responsible Party Information

Name: _____ Marital Status: Single Separated
 Married Divorced
Mailing Address _____
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 yrs.) _____
Social Security Number _____ Birthdate _____ Relationship to patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name: _____ Relationship to Patient _____
Spouse's Address (if different) _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security Number _____ Birthdate _____ Work Phone _____
Email Address _____ Home Phone (if different) _____

Dental Insurance Information

Policy Holder's Name _____ Insured's Soc. Sec. # _____ Birthdate ____ / ____ / ____
Insurance Co. _____ Group No. _____ Subscriber No. _____
Insurance Co. Address _____ Phone No. _____
Policy Holder's Employer _____ Do you have other dental insurance? No Yes

Emergency Information

Name of nearest emergency contact not living with you _____ Phone No. _____
Address _____ Relationship to patient _____

I understand that where appropriate, credit bureau reports may be obtained.

Signed: _____ Date: _____
(Patient)