PATIENT INFORMATION

Please Print
Patient Name: ____ Date: ______________
Last First MI (Preferred Name)

Sex: M F Marital Status: M S D W Birth Date: ____________ Social Security #: ______________

Address: ____ Home #: ______________
Street City State Zip Code

Employer Name: ____________________ Address: ______________________________________
Street City State Zip Code

Work #: ____________ Ext ______ Cell #: ____________ Driver's License # / State: ______________

Do You Pre-Medicate Before Appointments?: Yes No (if yes, please contact our office as soon as possible)

Emergency Contact: ________________________ Relationship: ______________ Phone: ______________

Whom may we thank for referring you to our office: ______________________________________

SPOUSE OR RESPONSIBLE PARTY INFORMATION (if other than Patient)

Name ____ Sex: M F Marital Status: M S D W
Last First MI (Preferred Name)

Birth Date: ____________ Social Security #: ______________ Driver's License # / State: ______________

Address: ____ Home #: ______________
Street City State Zip Code

Employer Name: ____________________ Address: ______________________________________
Street City State Zip Code

Work #: ____________ Ext ______ Other #: ________________

DENTAL INSURANCE INFORMATION

Primary
Name of Insured: ______________________________________ Insured's Birth Date: ______________

ID or SS #: ____________________ Group #: ____________________ Home #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ______________________________ Work #: ____________ Ext ______

Address: ____
Street City State Zip Code

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: ______________________________________ Phone #: ______________

Address: ____
Street City State Zip Code

Secondary
Name of Insured: ______________________________________ Insured's Birth Date: ______________

ID or SS #: ____________________ Group #: ____________________ Home #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ______________________________ Work #: ____________ Ext ______

Address: ____
Street City State Zip Code

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: ______________________________________ Phone #: ______________

Address: ____
Street City State Zip Code

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