PATIENT INTRODUCTION

TITLE:

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **BIRTHDATE**

STREET ADDRESS **APT # / UNIT**

CITY **STATE** **ZIP CODE**

TELEPHONE# **ALTERNATE# (CELL, PAGER)**

PATIENT EMPLOYER **OCCUPATION**

BUSINESS ADDRESS **BUSINESS TELEPHONE**

PATIENT SOCIAL SECURITY NUMBER (required if insurance policy holder or for personal check writing)

NAME OF SPOUSE

SPOUSE EMPLOYER **OCCUPATION**

BUSINESS ADDRESS **BUSINESS TELEPHONE**

SPOUSE SOCIAL SECURITY NUMBER (required if spouse is a dental policy holder under which you are insured)

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED? **TELEPHONE NUMBER**

IF PATIENT IS UNDER THE AGE OF 18, PARENT OR LEGAL GUARDIAN INFORMATION

MOTHER'S NAME _____ **MOTHER'S SS#**_____

ADDRESS _____ **HOME PHONE** _____

EMPLOYER _____**OCCUPATION**_____ **WORK PHONE** _____

FATHER'S NAME _____ **FATHER'S SS#** _____

ADDRESS _____ **HOME PHONE** _____

EMPLOYER _____**OCCUPATION** _____ **WORK PHONE** _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE **POLICY HOLDER'S NAME** **RELATIONSHIP TO INSURED**

ID / POLICY / CERTIFICATE # **PLAN NAME OR #** **GROUP #**

SECONDARY DENTAL INSURANCE **POLICY HOLDER'S NAME** **RELATIONSHIP TO INSURED**

ID / POLICY / CERTIFICATE # **PLAN NAME OR #** **GROUP #**

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE ?