Patient Information

Date_____

Patient's Name _____
Last First Middle

Address_____
Street City State Zip

Home Phone _____ Birthdate_____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

Responsible Party

Name_____
Last First Middle Marital Status

Residence _____
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

Social Security #_____ Birthdate _____ Relationship to Patient_____

Employer _____ Occupation _____ No. Years Employed ___

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed ___

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group # _____Insured Birthdate _____

Insurance Co. Address _____

Insured's Employer _____ Insured's Address _____
(if not shown above)

Do you have dual coverage? Yes No If yes:
Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group # _____Insured Birthdate _____

Insurance Co. Address _____

Insured's Employer _____ Insured's Address _____
(if not shown above)

Emergency Information

Name of nearest relative not living with you_____

Complete Address _____Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____