Patient Information

Patient Name_____Date_____
First Last (Preferred)

Email Address_____ Gender_____ Marital Status_____

Social Security#_____ Birth date _____

Phone (Home) _____Work _____Cell_____

Address: _____
Street Apartment #

_____
City State Zip

Person to Contact for an Emergency

Name_____ Phone#_____ Relation_____

Responsible Party Information

Name: _____ Relation to Patient: _____

Social Security# _____ Birth Date _____

Phone (Home) _____ Work _____Cell_____

Address _____
Street Apartment #

_____
City State Zip

Referral Information

Whom may we thank for referring you to our practice? ☐ Website ☐ Brochure ☐ Church bulletin
☐ Another Patient ☐ Another Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Work ☐ School ☐ Other

Name of person or office referring you to our practice _____

Employment Information

The following is for: ☐ the Patient ☐ Responsible Party

Employer Name_____ Occupation_____

Address_____
Street City/State Zip Phone #

Insurance Information

Primary

Name of Insured_____

Insured's Birth Date___ _____ID#_____Group#_____

Insured's Address_____ _____
Street City/State Zip

Insured's Employer Name_____ _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name_____

Claims Address_____

_____

_____

Insurance Phone#_____

Insurance Information

Secondary

Name of Insured_____

Insured's Birth Date_____ID#_____Group#_____

Insured's Address_____
Street City/State Zip

Insured's Employer Name_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name_____

Claims Address_____

_____

_____

Insurance Phone#_____