Patient Information

Patient Name: _____ **Date:** _____
Last, First MI (Preferred Name)

Gender: _____ **Family Status:** _____ **Birth Date:** _____

Social Security #: _____ ***Drivers License:*** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____

Cell Phone: _____ **EmailAddress:** _____

Address: _____
Street (If P.O. Box, please include street address) Apartment #

_____
City State Zip Code

EMERGENCY Contact Person: _____ **Relation:** _____ **Phone #:** _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____ **Best time to call:** _____

Address: : _____
Street (If P.O. Box, please include street address) Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ **Occupation:** _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary Dental Insurance:

Insurance Plan Name and Address: _____

Name of Insured: _____ **Is insured a patient?** ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Secondary Insurance Information

Insurance Plan Name and Address: _____

Name of Insured: _____ **Is insured a patient?** ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name & Address: _____
Name Street City State Zip Code

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