Patient Information

Name _____ Social Security # _____
(last name) (first name) (Initial)

Address _____ Home Ph:_____ Cell: _____

City _____ State_____ Zip Code _____

Sex ☐ M ☐ F Age_____ Birth Date _____ ☐Single ☐Married ☐Widowed ☐Separated/Divorced

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone: _____

Dental Insurance Information

Person Responsible for Account: _____
(last name) (first name) (Initial)

Relationship to Patient: _____ Birth date:_____ Social Sec.#_____

Address (if different from patient's) _____ Phone: _____

City:_____ State:_____ Zip:_____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company _____ ID/Contract/Subscriber # _____

Ins. Co. Phone # _____ Group # _____

Additional Dental Insurance Information

Is patient covered by additional dental insurance? ☐ Yes ☐ No

Person Responsible for Account: _____
(last name) (first name) (Initial)

Relationship to Patient: _____ Birth date:_____ Social Sec.#_____

Address (if different from patient's) _____ Phone: _____

City:_____ State:_____Zip:_____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company _____ ID/Contract/Subscriber # _____

Ins. Co. Phone # _____ Group # _____

If dental insurance applies: Although this office files insurance claims as a service to the patient the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient.

All information written is true and complete: SIGNATURE: _____Date: _____