----------Patient Information----------

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

E-mail Address for appointment reminders_____

Home Phone_____ Cell Phone _____ Patient's Birth Date_____

Patient's General Dentist_____

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

----------Responsible Party Information----------

Name_____ _____
Last First Middle Marital Status

Residence_____
Street City State Zip

How long at this address? ____ Home Phone_____ Cell Phone_____ Work Phone_____

Social Security #_____ Birth Date_____ Relationship to Patient _____

Employer_____Occupation_____ Number of years employed_____

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

Social Security #_____Birth Date_____ Cell Phone_____ Work Phone _____

Employer_____Occupation_____Number of years employed_____

----------Dental Insurance Information----------

Insured's Name_____ Insured's Soc. Sec. # _____ Insured's Birth Date _____

Insurance Company_____ Group or Subscriber # _____

Insurance Co. Address _____

2nd Dental Insurance Coverage

Insured's Name_____ Insured's Soc. Sec. # _____ Insured's Birth Date _____

Insurance Company_____ Group or Subscriber # _____

Insurance Co. Address _____Employer_____

----------Emergency Information ----------

Name of nearest relative not living with you_____

Complete Address_____

Phone _____

Signature (Parent's signature if minor) _____