Patient Information:

Date: _____

Home Phone: _____ Cell Number: _____

Name: _____ SSN #_____

Address: _____City:_____ State: _____ Zip Code: _____

Sex: M __ F __ Birthday: _____ Minor__ Single___ Married___

Parent/Patient Employer: _____Work Number:_____

Patient email address: _____

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

Emergency Information:
Please list two people to contact in case of an emergency. One CANNOT live with you, it does not have to be a relative and the other can be your spouse/significant other:

Name: _____ Home Phone: _____

Name: _____ Cell Number_____

Responsible Party: (The person paying on the account. Not your insurance.)

Name: _____Birth Date: _____ SSN # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Work number: _____

Has anyone in your family been in our office? _____Relationship:_____

Insurance Information:

Insured Name: _____Relationship to Patient: _____ Birth date:_____

Insured Employed by: _____ Phone: _____

Insurance Company _____ Phone: _____

Group # _____ Subscriber/ID # _____

Is the patient covered by a secondary dental insurance: Y ___ N __?

Insured Name: _____Soc. Sec. #_____ Birth Date:_____

Insurance company _____ phone number # _____

Insured's Employer: _____Business Phone: _____

Group # _____ Subscriber/ID # _____

Appointment Policy:

*Your appointment time has been reserved especially for you. If you cannot keep your appointment you can avoid a **$50.00** charge by giving us at least 24-hour notice.*