PATIENT INFORMATION:

Today's Date: _____/_____/_____

Home Phone: _____ Cell Number: _____

Name: _____ SSN #_____

Address: _____City: _____ St: _____ Zip Code: _____

Sex: M ___ F ___ Birthday: _____ Minor___ Single___ Married___

Parent/Patient Employer: _____ Work Number: _____

Patient email: _____

Pharmacy Name & Number (or address) _____

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: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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

Name: _____ D.O.B: _____ SSN # _____

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

Employer: _____ Work number: _____

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

Dental Insurance Information:

Policy Holder's Name: _____ D.O.B: _____ SSN # _____

Insurance Company: _____ Phone: _____

Insured's Employer: _____ Phone: _____

Group # _____ Subscriber/ID # _____

Is the patient covered by a secondary dental insurance? Do you have two dental insurances? Y ___ N __

Policy Holder's Name: _____ D.O.B: _____ SSN # _____

Insurance Company: _____ Phone: _____

Insured's Employer: _____ Phone: _____

Group # _____ Subscriber/ID # _____