Patient Information (Confidential)

To help us meet your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

NAME_____SS#_____
Last First Middle In.

MARRIED___SINGLE___ MALE___FEMALE___SPOUSE/PARENT NAME_____

BIRTHDATE_____PHONE #_____
Month Day Year Home Work Cell

MAILING ADDRESS_____
City State Zip

PHYSICAL ADDRESS_____
City State Zip

EMAIL ADDRESS_____

EMPLOYER _____
Phone #

PERSON RESPONSIBLE FOR ACCOUNT_____
Birthdate

RELATIONSHIP TO PATIENT_____PHONE #_____
Home Work Cell #

MAILING ADDRESS_____
City State Zip

EMPLOYER_____PHONE #_____

_____
Nearest Relative Address Phone #

_____
List all who are authorized to seek treatment for your minor children (Aunts, Uncles, Friends etc…)

Who can we thank for referring you _____

INSURANCE INFORMATION

Dental Primary Insurance

Name of Subscriber_____Subscribers Birth Date_____SS#_____

Employer_____Employer Phone #_____

Insurance Company_____Insurance Phone #_____

Subscribers ID#_____Group #_____

Dental Secondary Insurance

Name of Subscriber_____Subscribers Birth Date_____SS#_____

Employer_____Employer Phone #_____

Insurance Company_____Insurance Phone #_____

Subscribers ID#_____Group #_____

Signature_____Date_____