

Patient Information

Patient Name: _____
Last First Mid Preferred Name

Gender: Male Female Marital Status: Single Married Child Widowed Divorced

Date of Birth: _____ SS#: _____

Employer: _____ Occupation: _____

How did you hear about us? _____
(If referred by another person, may we thank them on your behalf? _____)

Student Status if over 19 (for ins): Non-Student Full-Time Student Part-Time Student

College Name: _____

Contact Information

Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Wireless #: _____ Okay to Text for Appointment Reminders: Yes No

Work #: _____ Okay to contact at this number? Yes No

Email: _____

Preferred method of contact: Cell # Home # Work # E-mail Text

Emergency Information

Drivers License #: _____

**please provide a copy of your license to the receptionist. Thank you!

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone #: _____

Responsible Party (Financial)

Please check here if same as above

Name: _____ Relationship to Patient: _____

Address: _____ City, State, Zip: _____

Wireless #: _____ Home # _____ Email: _____

Birthdate: _____ Soc Sec #: _____ Drivers License # _____

Primary Dental Insurance

Relationship to Subscriber: Self Spouse Child

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SS#: _____ Subs ID: _____

Subscriber Group #: _____ Group Name: _____

Subscriber's Employer: _____

Insurance Company: _____ Insurance Phone Number: _____

Date you started this plan: _____

*please present insurance cards and ID to receptionist

Secondary Dental Insurance

Relationship to Subscriber: Self Spouse Child

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SS#: _____ Subs ID: _____

Subscriber Group #: _____ Group Name: _____

Subscriber's Employer: _____

Insurance Company: _____ Insurance Phone Number: _____

Date you started this plan: _____

*please present insurance cards and ID to receptionist

Signature of Patient/Guardian: _____ Date: _____