

Patient Information



Patient's Name _____ Date _____ 20____
Male _____ Female _____
Last First Middle Nickname

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell/Pager # _____

Patient Birth Date _____ Patient Social Security Number _____

Patient E-Mail Address _____

Responsible Party Information

Name _____
Last First Middle

Address _____
Street City/State Zip

Home Phone _____ Work Phone _____ Cell/Pager # _____

Birth Date _____ Social Security Number _____

Employer _____ Occupation _____

Spouse's Name _____

Home Phone _____ Work Phone _____ Cell/Pager # _____

Spouse's Birth Date _____ Spouse's Social Security Number _____

Employer _____ Occupation _____

Dental Insurance Information

Insured's Name _____
Last First Middle

Insured's Birth Date _____ Insured's Social Security Number _____

Insured's Employer _____ Insured's Dental Insurance Co. _____

Dental Insurance Company Phone Number _____ Dental Insurance Group Number _____

Dental Insurance Address _____

Do you have dual coverage? No Yes If yes, please complete the following

Insured's name _____ Insured's S.S.# _____

Dental Insurance Co. _____ Group No. _____

Insurance Co. Address _____

Emergency Notification Information

In case of emergency, who should be notified?

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

To the best of my knowledge all the preceding answers are true and correct.
I will inform your office of any changes at the next appointment.

Signature of Patient or Guardian Date