PATIENT INFORMATION **DATE**_____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER _____

ADDRESS _____
STREET CITY STATE ZIP CODE

BIRTHDATE _____ EMAIL _____

TELEPHONE _____
CELL HOME WORK

EMPLOYER OR SCHOOL _____

PERSON RESPONSIBLE FOR ACCOUNT – CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ MOTHER ☐ FATHER

DENTAL INSURANCE INFORMATION

INSURED NAME _____ BIRTHDATE _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP CODE

EMPLOYER _____ SOCIAL SECURITY NUMBER _____

INSURED'S RELATIONSHIP TO PATIENT: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ MOTHER ☐ FATHER

DENTAL INSURANCE COMPANY_____

SUBSCRIBER # _____ GROUP # _____

EMERGENCY CONTACT

NAME _____ PHONE NUMBER _____

RELATIONSHIP TO PATIENT: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ MOTHER ☐ FATHER

OTHER INFORMATION

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? CHECK ALL THAT APPLY:

☐ TEXT ☐ EMAIL ☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ POSTCARD

PATIENT OR RESPONSIBLE PARTY

_____
SIGNATURE DATE