

PATIENT INFORMATIONPatient Name: *First:* _____ *Middle Initial:* _____ *Last:* _____Patient Preferred Name: _____ Birthdate: _____ Male Female/ Single Married

Cell phone: (_____) _____ Home phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Responsible Party: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____

Whom may we thank for referring you? Dr. _____ /Friend _____

EMERGENCY INFORMATION

In case of emergency, who should we notify? _____

Phone: (_____) _____ Second Phone: (_____) _____

DENTAL INSURANCE (Primary)Policy Holder Name: *First:* _____ *Middle Initial:* _____ *Last:* _____

Relationship to Patient: _____ Policy Holder Date of Birth: _____

Policy Holder SS/ID#: _____ Group #: _____

Policy Holder Employer/Company: _____ Insurance Company: _____

Self-Insured: Yes NoStatus: Full-Time Part-Time Retired**DENTAL INSURANCE (Secondary)**Policy Holder Name: *First:* _____ *Middle Initial:* _____ *Last:* _____

Relationship to Patient: _____ Policy Holder Date of Birth: _____

Policy Holder SS/ID#: _____ Group #: _____

Policy Holder Employer/Company: _____ Insurance Company: _____

Self-Insured: Yes NoStatus: Full-Time Part-Time Retired**SIGNATURE**

Signature: _____ Date: _____