

PATIENT INFORMATION

CONFIDENTIAL

DATE _____

Patient name _____ Soc. Sec. # _____
 Address _____ Birth Date _____
 City _____ State _____ Zip _____ Home Phone _____
 Sex: M F Age _____ Minor Single Married Widowed Separated Divorced
 If patient is a student, name of school/college _____ City _____
 Patient employed by _____ Business Phone _____ Occupation _____
 In case of emergency who should be notified? _____ Phone _____
 Whom may we thank for referring you? _____ E-mail _____
 Would you like to be reminded of appointments by e-mail? Yes No Would you like to receive dental discounts and office info by e-mail? Yes No

Primary Insurance

Person Responsible for account _____
 Relationship to patient _____ Birth Date _____ Soc. Sec. # _____
 Address (if different than patient's) _____
 City _____ State _____ Zip _____ Home Phone _____
 Employer _____ Occupation _____
 Address _____ Business Phone _____
 City _____ State _____ Zip _____
 Insurance Company _____ Group No. _____ Union or Local # _____
 Address _____ City _____ State _____ Zip _____
 Names of other dependents covered under this plan _____

Secondary Insurance

Subscriber Name _____ Relationship to patient _____
 Birth Date _____ Soc. Sec. # _____ Occupation _____
 Employer _____ Business Phone _____
 Address _____ City _____ State _____ Zip _____
 Insurance Co. _____ Group No. _____ Union or Local # _____
 Address _____ City _____ State _____ Zip _____
 Names of dependents covered under this plan _____

Signature of Patient or Parent if Patient is a Minor

I hereby give the treating dental staff permission to provide dental services including but not limited to oral examinations, x-rays and prophylaxis. A detailed consent form will be utilized for extensive treatment plans.