Today's Date: ___/___/_____

Patient Information

Patient Name: _____
Last **First** **MI**

☐ Male ☐ Female Birth Date: _____/_____/_____

Social Security #: _____-____-_____

Home: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

E-Mail: _____

Address: _____ _____
Street **Apt #**

_____ _____ _____
City **State** **Zip Code**

Whom may we thank for referring you to our practice? _____

Responsible Party Information

****This section designates whoever is financially responsible for the patient****

If 'self' please check mark this box ☐

Name: _____
Last **First** **MI**

Birth Date: ___/___/_____ SS#:_____ Relationship to Patient: _____

Dental Insurance Information

****Please have your insurance card available****

Primary Dental Insurance:

Name of Insured: _____
Last **First** **MI**

Insured's Birth Date: ___/____/_____ Employer Name: _____

Insurance Company Name: _____ SS# or ID#: _____

Secondary Dental Insurance (*If applicable*):

Name of Insured: _____
Last **First** **MI**

Insured's Birth Date: ___/____/_____ Employer Name: _____

Insurance Company Name: _____ SS# or ID #: _____