

**PATIENT INFORMATION (Please Print)**

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ Apt./Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phones: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Mobile: ( ) - \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) - \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred By: \_\_\_\_\_ General Dentist: \_\_\_\_\_

Have you been seen in this practice before today?  Yes  No

**PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)**

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to Patient:  patient  spouse  child  other - please specify \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phones: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Mobile: ( ) - \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) - \_\_\_\_\_ Occupation: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**Primary Insurance**

Ins. Co. \_\_\_\_\_

Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

**Employee (if other than patient)**

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Sex:  Male  Female

**Secondary Insurance**

Ins. Co. \_\_\_\_\_

Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

**Employee (if other than patient)**

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Sex:  Male  Female

Signature (parent or guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_

Signature of authorized representative \_\_\_\_\_ Date \_\_\_\_\_