Patient Information

Patient's Name:____

Address:____

Birthdate:_____________**Social Security #**______-____-______**Preferred Contact:**____________________

Home Phone: ________________**Cell:** ________________**E-mail:** ________________________________

Who can we thank for referring you to our office? ____

Responsible Party Information

Name:____**Circle One:** Single Married Other

LAST FIRST MIDDLE

Residence:____

STREET CITY STATE ZIP

Mailing Address:____

(If different) STREET CITY STATE ZIP

How long at this address?_____________**Home Phone:**_________________**Cell:**_______________________

Previous Address (if less than 3 yrs.)____

STREET CITY STATE ZIP

Social Security #_____-____-_____**Birthdate:**____________**Relationship to Patient:**_____________________

Your Employer:_________________**Occupation:**________________**No. Years Employed:**_______________

Spouse's Name:________________________________**Relationship to Patient:**_________________________

Spouse's Employer:______________________**Occupation:**___________________**No. Years Employed:**____

Spouse's Social Security #_____-____-_____**Birthdate:**____________**Phone #**________________________

Insurance Information

Subscriber/Insured's Name:_________________________**Insurance ID #**______________________________

Insurance Company:___________________________________**Do you have secondary insurance? YES or NO**

Other/Secondary Insurance Info:

Emergency Contact

Name of nearest relative:_______________________________**Relationship:**___________________________

Complete Address____**Phone:**__________________________

I authorize release of any information necessary for the filing of insurance claims. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dentist of the insurance benefits otherwise payable to me.

Signature of Patient/Responsible Party _____________________________**Date:**_____________