Patient Information

Name_____ **Soc. Sec. #**_____
Last Name **First Name** **Initial**

Address_____

City_____**State**_____**Zip**_____**Phone**_____

Sex ☐**M** ☐**F** **Age**_____ **Birthdate**_____ ☐**Single** ☐**Married** ☐**Widowed** ☐**Separated** ☐**Divorced**

Patient Employed by _____ **Occupation**_____

Business Phone _____ **Cell Phone** _____

Notify in case of emergency_____ **Home Phone**_____ **Work Phone**_____

What doctor referred you to us?_____

Email Address_____

Primary Dental Insurance

Person Responsible for Account_____
Last Name **First Name** **Initial**

Relation to Patient_____ **Birthdate**_____ **Soc. Sec. #** _____

Address (if different from patient) _____ **Home Phone**_____

City_____ **State**_____ **Zip**_____

Person Responsible Employed by_____ **Occupation**_____

Insurance Company _____ **Phone**_____

Insurance Claims Mailing Address_____

Group # _____ **Subscriber #** _____

Additional Dental and/or Medical Insurance

Is patient covered by additional insurance? ☐**Yes** ☐**No**

Subscriber Name_____ **Relation to Patient**_____ **Birthdate**_____

Address (if different from patient) _____ **Soc. Sec. #**_____

City_____**State**_____ **Zip**_____ **Phone** _____

Subscriber Employed by_____ **Business Phone**_____

Insurance Company _____ **Phone**_____

Insurance Claims Mailing Address_____

Group # _____ **Subscriber #** _____