

**PATIENT INFORMATION**

Date \_\_\_\_\_ Marital Status \_\_\_\_\_

Patient Name \_\_\_\_\_ Sex  Male  Female  
First Middle Last Nickname

Address \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ Home Phone No. \_\_\_\_\_

Cell Phone No. \_\_\_\_\_ Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Number \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Primary Care Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Nearest friend or relative not living with you \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**REFERRAL INFORMATION**

Were you referred by one of our Patients?  Yes  No

If yes, who may we thank? \_\_\_\_\_

If no, how did you find us? \_\_\_\_\_

**RESPONSIBLE PARTY**

Responsible party \_\_\_\_\_ Home Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Previous Address (if less than 3 years at above address) \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Responsible party's employer \_\_\_\_\_ Work Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**DENTAL INSURANCE INFORMATION**

insurance Co. \_\_\_\_\_ Effective Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Name of Subscriber's Employer \_\_\_\_\_ Group No. \_\_\_\_\_

Subscriber name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS No. \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Effective Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Name of Subscriber's Employer \_\_\_\_\_ Group No. \_\_\_\_\_

Subscriber name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS No. \_\_\_\_\_

Signature (Parent or Guardian's signature if minor) \_\_\_\_\_

Updates (Date and Initial) \_\_\_\_\_