Name: _____ Sex: ____ M ____F

Home Phone: _____ Work Phone:_____ Cell Phone: _____

Email Address: _____

Home Address: _____City: _____ Zip Code: _____

Drivers License Number: _____ State: _____ Exp. Date: _____

Employer Information

Employer Name and Address: _____

Employer Phone: _____

Spouse's Name: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Previous Dentist: _____ Phone: _____

Whom may we contact in the case of an emergency?_____ Phone: _____

Whom may we thank for referring you to us?_____ Phone: _____

Who is responsible for this bill? _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #:_____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

Do you have Secondary Insurance? ___Yes ___No

Name of Insured: _____Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of employer: _____ Office Phone: _____

Insurance Company: _____ Group #: _____ Employer/ID# _____

Insurance company address: _____ City/State: _____ Zip: _____

If this claim is accident related, please provide details of the accident: _____