

Date: _____

Please print the following completely. Your answers are considered confidential.

PATIENT INFORMATION

RESPONSIBLE PARTY INFORMATION
(If different than Patient)

Circle One: Mr. Mrs. Miss. Ms. Other _____

Circle One: Mr. Mrs. Miss Ms. Other: _____

Name: _____

Name: _____

I preferred to be called (name): _____

Relationship to Patient: _____

Mailing Address: _____

Mailing Address: _____

Physical Address: _____

Physical Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Place of Employment: _____

Place of Employment: _____

Soc. Sec. ID Number: _____

Soc. Sec. ID Number: _____

Sex: () M () F Birth Date: ____ / ____ / ____

Sex () M () F Birth Date: ____ / ____ / ____

Spouse Name: _____

Spouse Name: _____

INSURANCE INFORMATION

Do you have dental insurance? () Yes () No Insurance Company: _____

Do you have medical insurance? () Yes () No Insurance Company: _____