Patient Information

Patient Name: _____ _____ ____ _____
Last First Mid Prefered Name

Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Child ❑Widowed ❑Divorced
Date of Birth: _____ SS#: _____
Employer: _____ Occupation: _____
How did you hear about us? _____
(If referred by another person, may we thank them on your behalf?_____)
Student Status if over 19 (for ins): ❑Non-Student ❑Full-Time Student ❑Part-Time Student
College Name:_____

Contact Information

Home Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Wireless #: _____ Okay to Text for Appointment Reminders: ❑Yes ❑No
Work #:_____ Okay to contact at this number? ❑Yes ❑No
Email: _____
Preferred method of contact: ❑Cell # ❑ Home # ❑Work # ❑E-mail ❑Text

Emergency Information

Drivers License #: _____
**pease provide a copy of your license to the receptionist. Thank you!
Emergency Contact: _____ Relationship to Patient: _____
Emergency Contact Phone #: _____

Responsible Party (Financial)

❑Please check here if same as above
Name: _____ Relationship to Patient: _____
Address: _____ City, State, Zip: _____
Wireless #: _____ Home #_____ Email: _____
Birthdate: _____ Soc Sec #: _____ Drivers License #_____

Primary Dental Insurance

Relationship to Subscriber: ❑Self ❑Spouse ❑Child
Subscriber Name: _____ Subscriber DOB: _____
Subscriber SS#:_____ Subs ID: _____
Subscriber Group #: _____ Group Name: _____
Subscriber's Employer: _____
Insurance Company: _____ Insurance Phone Number: _____
Date you started this plan: _____
*please present insurance cards and ID to receptionist

Secondary Dental Insurance

Relationship to Subscriber: ❑Self ❑Spouse ❑Child
Subscriber Name: _____ Subscriber DOB: _____
Subscriber SS#:_____ Subs ID: _____
Subscriber Group #: _____ Group Name: _____
Subscriber's Employer: _____
Insurance Company: _____ Insurance Phone Number: _____
Date you started this plan: _____
*please present insurance cards and ID to receptionist

Signature of Patient/Guardian: _____ Date: _____