PATIENT INFORMATION

Date_______________

Patient's Name____ Preferred Name____________

Date of Birth____________Age______Sex________Hobbies/Interests___________________________

Address____

Home Phone______________School__________________________________Grade______________

If patient is a minor give parent's or guardian's name____

Dentist______________________________Physician____

Who referred you to our office____

RESPONSIBLE PARTY INFORMATION

Name_____________________________________Relationship to Patient_____________________

Address (if different from patient's)____

Home Phone_______________Cell Phone______________E-Mail______________________________

Marital Status_______________Social Security#____

Employer______________________________________Occupation________________________________

Spouse's Name___________________________Employer___________________________________

Social Security #______________________Birthdate________________Work Phone_____________

DENTAL INSURANCE INFORMATION

Insured's Name_____________________________Social Security #___________________________

Insurance Company_________________________________Group No.___________________________

Insurance Co Address_________________________________Phone No.______________________

Insured's Date of Birth________________Do you have more than one insurance?? Yes____ No____

Employer____

If Yes: Who carries the primary insurance?____

Insured's Name__________________________Insured's Social Security #______________________

Insurance Company __________________________Group No. ______________________________

Insurance Company Address______________________________Phone_________________________

Insured's Date of Birth____

Employer____

SIBLINGS OR CHILDREN OF PATIENT

Name______________________________Birthdate______________________Age________

Name______________________________Birthdate______________________Age________

Name______________________________Birthdate______________________Age________