

Date _____

Confidential Patient Information

A B C

Patient's Name _____
Last First Middle Nickname M / F

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____

If patient is a minor, give parent's or guardian's name _____

List brothers / sisters with age (add asterisk (*) after name if patient has been seen by us): _____

Whom may we thank for referring you to our office? _____

General Dentist: _____

Confidential Responsible Party Information

Responsible for Appointments

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Responsible for Financial Accounts

Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Policy Holder's Name _____ Birthdate _____ Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ Birthdate _____ Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative/friend not living with you _____

Complete Address _____

Phone _____ Relationship _____

