Today's Date: _____

Patient Information

Name: _____ ☐ Married ☐ Single ☐ Child ☐ Other: _____
Last First Mi

☐ Male ☐ Female

Birth Date: _____

Social Security #: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Mailing Address: _____
Street Apt #

_____
City State Zip Code

Physical Address: _____
☐ same as above Street Apt #

_____
City State Zip Code

Email Address: _____

Spouse, Parent/Guardian, Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's parent/guardian ☐ the person responsible for payment

Name: _____ ☐ Married ☐ Single ☐ Child ☐ Other: _____
Last First Mi

☐ Male ☐ Female

Birth Date: _____

Social Security #: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Mailing Address: _____
Street Apt #

_____
City State Zip Code

Physical Address: _____
☐ same as above Street Apt #

_____
City State Zip Code

Email Address: _____

Dental Insurance Information

(Please present insurance card to front desk)

Primary Insurance

Name of Dental Insurance: _____

Name of Policyholder: _____

Policyholder's Date of Birth: _____

Policyholder's ID # or SSN: _____

Name of Employer: _____

Policy/Group #: _____

Secondary Insurance

Name of Dental Insurance: _____

Name of Policyholder: _____

Policyholder's Date of Birth: _____

Policyholder's ID # or SSN: _____

Name of Employer: _____

Policy/Group #: _____

Referral Information

☐ Postcard ☐ Yellow Pages ☐ Letter ☐ Radio (96.7 or 106.3) ☐ Internet ☐ Word of Mouth ☐ Other: _____

Name of patient we may thank for referring you to our practice: _____

Name of dental office referring you to our practice: _____