Patient Information

Date_____ Patient Name_____ Age_____

Last First Middle

Address_____

Home Phone_____ Cell Phone_____ Birth Date_____ Sex_____

E-Mail address_____ Dentist_____ Referred by_____

Preferred method of contact_____ List other family members treated here:_____

Employer_____ Occupation_____ # of years employed_____

Insurance Information

Policy Holder's Name_____ Employer_____

Insurance Company_____ Group/Policy#_____

Insurance Co. Address_____ Insurance Co. Phone #_____

Policy Holder Birth Date_____ Policy Holder Social Security #_____

Secondary Insurance_____ Policy Holder Name_____

Policy Holder Birth Date_____ Policy Holder Social Security # _____

Responsible Party Information

(If patient is responsible party, no need to fill out this portion)

Mother's Name_____ Birth Date_____ SS # _____

Address _____

Home Phone_____ Cell Phone_____ Employer_____

Father's Name_____ Birth Date_____ SS # _____

Address_____

Home Phone_____ Cell Phone_____ Employer_____

Step Parent Name_____ Address_____ Phone_____