Welcome

*PATIENT INFORMATION: TODAYS DATE: _____

NAME:_____ PREFERRED NAME:_____

BIRTHDATE:_____ SS#_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PH:_____ WORK PH:_____ CELL PH:_____

CHECK ONE: SINGLE_____ MARRIED_____ DIVORCED_____WIDOWED_____ SEPARATED_____

EMPLOYER: _____ OCCUPATION:_____

***IN CASE OF EMERGENCY CONTACT: _____ RELATIONSHIP:_____**

PHONE #: _____

*RESPONSIBLE PARTY: (WHO IS RESPONSIBLE FOR ACCOUNT)

NAME:_____ RELATIONSHIP TO PATIENT:_____

BIRTHDATE:_____ SS#:_____ HOME PH:_____

ADDRESS:_____ CITY:_____ STATE:___ ZIP:_____

EMPLOYER:_____ WORK PH:_____ OCCUPATION:_____

*INSURANCE INFORMATION:(PRIMARY)

POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

BIRTHDATE:_____ SS#:_____ WORK PH:_____

INSURANCE CARRIER NAME:_____

DO YOU HAVE ADDITIONAL DENTAL INS.? IF YES, COMPLETE THE FOLLOWING:

POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

BIRTHDATE:_____ SS#:_____ WORK PH:_____

INSURANCE CARRIER NAME:_____