PATIENT INFORMATION

Name:_____ Phone#:_____
Last First Middle

Home Address:_____
Street City State Zip

Patient SS#:_____ Birth Date:_____

Age:_____ Sex:_____ Marital Status:_____

Patient Employer:_____ Occupation:_____

Full-Time Student: Y or N Name of School:_____

Employer Address:_____
Street City Zip

Home Phone#:_____ Work Phone#:_____ ext._____

Alternate Phone#:_____

Who can we thank for referring you to our office?_____

Who is your general dentist? Name:_____ Phone#_____

Who is your physician? Name:_____ Phone#_____

What is your **pharmacy?** Name:_____ Phone#:_____

INSURANCE INFORMATION

Responsible Person:_____ Birth Date:_____
Last First Middle

Address:_____
Street City Zip

Home Phone:_____ Work Phone:_____

Relationship to Patient:_____ SS#:_____

Employer:_____ Position:_____

Employer's Address:_____
Street City Zip

Insurance Company:_____ Group#:_____

Contact#:_____ Effective Date:_____

EMERGENCY CONTACT (Please list a relative or friend not living with you)

Name:_____ Home Phone:_____
Last First Middle

Home Address:_____
Street City State Zip

Relationship:_____ Work Phone:_____

Legal Responsible party. If a patient is a minor or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

_____ _____
Patient's Signature/Responsible Party *Date*