Patient Information

Date_____

Patient's Name _____
Last First Middle Preferred Name

Address _____
Street City State Zip

Home Phone _____ Work Phone_____ Birthdate _____

Employer _____
Name Address

If a child, please give Parent's or Legal Guardians Name _____ S.S. # _____

Responsible Party Information (If information is different from above)

Name _____ Relationship _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Birthdate _____ S.S. # _____

Employer _____
Name Address

Dental Insurance Information (* Please do not repeat information unless it is different from above)

Insured's Name _____
Last First Middle

*Address _____
Street City State Zip

*Insured's S.S. # (for insurance purposes only)_____

Dental Insurance Company _____

Group # _____ Local #_____

*Insured's Employer _____
Name Address Phone

Do you have dual coverage? ☐Yes ☐No If yes, please complete the following:

Insured's Name _____
Last First Middle

Address _____
Street City State Zip

Insured's S.S. # (for insurance purposes only)_____

Dental Insurance Company _____

Group # _____ Local #_____

Insured's Employer _____
Name Address Phone

Emergency Notification Information

In case of an emergency, who should be notified? Name _____

Home phone _____ Work phone_____ Cell phone _____

Signature _____ Date _____