Patient Information

Name: ______________________ Birthdate: ______________ Social Security Number: ______________

Address: ______________________________ City: __________ State: _________ Zip: __________

E-mail: ________________________ Home Phone: _______________ Cell Phone: _______________

Who may we thank for referring you?: ____

Emergency contact: ______________________________ Phone Number: ________________________

Responsible Party (if other than patient)

Name: _______________ Birthdate: _________ Relationship: ________ Social Security Number: _________

Address: ______________________________ City: __________ State: _________ Zip: __________

E-mail: ________________________ Home Phone: _______________ Cell Phone: _______________

Dental Insurance Information

Name of Insured: __________________________________ Relationship to Patient: _________________

Birthdate: __________________ Social Security Number: __________________ Phone: ______________

Employer: ______________________________________ Work Phone: _________________________

Insurance Company: ____________________ Group #: _______________ Member ID: _______________

Insurance Address: ____________________________ City: ________ State: ________ Zip: ________

Secondary Insurance Information (if applicable)

Name of Insured: __________________________________ Relationship to Patient: _________________

Birthdate: __________________ Social Security Number: __________________ Phone: ______________

Employer: ______________________________________ Work Phone: _________________________

Insurance Company: ____________________ Group #: _______________ Member ID: _______________

Insurance Address: ____________________________ City: ________ State: ________ Zip: ________