Pt. #______________

Confidential Patient Information

Date_______________

Patient's Name____ M / F
Last First Middle Nickname

Address____
Street City State Zip

Phone_________________________ Age: _________ Birthdate_________________ School _________________________________

Whom may we thank for referring you to our office?____

Siblings	DOB	M/F	Siblings	DOB	M/F

Siblings	DOB	M/F	Siblings	DOB	M/F

Responsible Party Information

Name____
Last First Middle

Marital Status (mark one)
M W S Div Sep Partner

Residence____
Street City State Zip

Email___________________________________Mailing Address_______________________________________
Street City State Zip

How long at this address_____________ Previous Address_______________________________________
(if less than 3 yrs) Street City State Zip

Home Phone______________________________ Work Phone______________________________Cell Phone________________________

Social Security #______________________________ Birthdate______________________ Relationship to Patient______________________

Employer_________________________________ Occupation___________________________________ No. Years Employed_______

Spouse's Name____ Relationship to Patient______________________
Last First Middle

Employer_________________________________ Occupation___________________________________ No. Years Employed_______

Social Security #______________________________ Birthdate______________________ Cell Phone______________________________

Dental Insurance Information

Policy Holder's Name____ Soc.Sec. # ___________________________

Insured's DOB:_____________ Insurance Company_________________________________ Group No.______________

Insurance Co. Address____ Insurance Co. Phone____________________

Policy Holder's Employer____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name____ Soc. Sec. # ___________________________

Insured's DOB:_____________ Insurance Company_________________________________ Group No.______________

Insurance Co. Address____ Insurance Co. Phone____________________

Policy Holder's Employer____

Emergency Contact Information

Name of nearest relative not living with you____ Relationship______________

Address____Phone______________________________________

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor)____

Updates (date & initial)____