Patient Information

Patient's Name: ______________________________ ______________________
Last First Middle Initial How do you wish to be addressed

If patient is a minor give Parent or Guardian's Name ______________________

Today's Date ______________ Marital Status: [] Single [] Married [] Divorced [] Widowed [] Separated Sex: [] Male [] Female

______________ ______ ______________ ______________
Date of Birth Age Social Security Number Driver's License Number

How did you hear about our office: Family /Friend ______________ Yellow Pages [] Internet [] Sign/Location [] Insurance [] Other []

Responsible Party Information

Name Last______________ First ______________ Middle Initial _____ Marital Status ______________

Residence Street ______________ Apt # ________ City ________ State _____ Zip Code ________

Mailing Address ______________ Apt # ________ City ________ State _____ Zip Code ________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Previous Address if less than 3 years ______________________________
Street City State Zip Code

______________ ______________ ______________ ______________
Social Security Number Date of Birth Driver's License Number Relationship to Patient

Employer ______________ Occupation ______________ No. Years Employed ________

Responsible Party Spouse

Name Last______________ First ______________ Middle Initial _____ Date of Birth ______________

Employer ______________ Occupation ______________ No. Years Employed ______________

Work Phone ______________ Cell Phone ______________ Social Security Number ______________

Emergency Information – Relative not living with you

Name ______________________________ Relationship ______________

Address ______________________________
Street City State Zip Code

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Dental Insurance Information (Primary Carrier)

Insured's Name ______________ Social Security # ______________ Date of Birth ______________

Insurance Company ______________ Insured's Employer ______________

Insurance Company Address ______________________________
Street City State Zip Code

Insurance Company Phone # ______________ Group Number/Local Number ______________

Dental Insurance Information (Secondary Carrier)

Insured's Name ______________ Social Security # ______________ Date of Birth ______________

Insurance Company ______________ Insured's Employer ______________

Insurance Company Address ______________________________
Street City State Zip Code

Insurance Company Phone # ______________ Group Number/Local Number ______________