Patient Information

Date _____ _____

Patient's Name _____ Male _____ Female _____
Last First Middle Nickname

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Birthdate _____

If a child, give parent's or Guardian's Name _____ S.S.# _____

Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Address _____ Birthdate _____
Street City State Zip

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

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Birthdate _____
Last First Middle

Home Phone _____ Work Phone _____

Employer _____ Occupation _____ No.Years Employed _____

Dental Insurance Information

Insured's Name _____ Insured's S.S.# _____
Last First Middle

Dental Insurance Company Address _____
Street City State Zip

Date of Marriage _____ Date of Employment _____ Effective date of Dental Insurance _____

Insured's Employer _____ Employer's Address _____ Phone _____

Do you have dual coverage? No YES If Yes complete the following:

Insured's Name _____ Insured's S.S.# _____
Last First Middle

Dental Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____
Street City State Zip

Insured's Employer _____ Employer's Address _____ Phone _____

Date of Employment _____ Effective date of Dental Insurance _____

Emergency Notification Information

In case of emergency, who should be notified?

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

To the best of my knowledge all the preceeding answers are true and correct.
I will inform your office of any changes at the next appointment.

_____
Signature of Patient or Guardian Date