Patient Information

Date _____

Patient's Name _____ Birthdate _____
Last First Middle

Address _____
Street City State Zip Code

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____ Gender M / F

If patient is a minor, parent's or guardian's name _____

How did you hear about our office? _____

Responsible Party Information

Name _____ Marital Status _____
Salutation Last First Middle

Address _____
Street City State Zip Code

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed ____

Spouse's Name _____
Salutation Last First Middle

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed ____

Dental Insurance Information

Insured's Name _____ Insured's Social Security Number _____

Insurance Company _____ Policy No. _____ Group No. _____

Insurance Co. Address _____

Insured's Employer _____

Do you have duel coverage? YES ___ NO ___

Insured's Name _____ Insured's Social Security Number _____

Insurance Company _____ Policy No. _____ Group No. _____

Insurance Co. Address _____

Insured's Employer _____

Patient Health History

Dentist's Name _____ Address _____

Physician's Name _____ Address _____

I understand that where appropriate, credit bureau reports may be obtained. (initial) _____

I have reviewed HIPPA form. (initial) _____

Signature (Parent/Guardian Signature if Minor)_____

Relationship to Patient _____