Today's Date ___________________
Who can we thank for referring you? _____________________________________

Patient Information

NAME ____
ADDRESS ____
CITY _________________________________ STATE ___________________ ZIP ___________________
HOME (_____)___________________WORK (_____) _________________ CELL(_____)______________________
E-MAIL ____

Patient Personal Information

BIRTH DATE __________________ SOCIAL SECURITY ____________________________
MARITAL STATUS _______________ IF MARRIED, SPOUSE'S NAME _______________________________
DO YOU HAVE ANY CHILDREN? ____ WHAT ARE THEIR NAME & AGES? _________________________
____
EMPLOYER ____

Emergency Contact

NAME ____ RELATIONSHIP______________________________
PHONE ______________________ CELL_____________________ WORK ______________________________

Responsible Party

NAME OF PERSON ULTIMATELY RESPONSIBLE FOR THIS ACCOUNT AFTER ALL INSURANCE HAS BEEN PAID?
____ RELATIONSHIP TO PATIENT _______________________

Dental Insurance Information

SUBSCRIBER NAME ___________________________ SUBSCRIBER DOB_______________________
EMPLOYER (IF DIFFERENT THAN ABOVE) ____
INSURANCE COMPANY ____
SUBSCRIBER ID ______________________________ GROUP# _________________________________

DO YOU HAVE SECONDARY DENTAL BENEFITS? YES OR NO

SUBSCRIBER NAME __________________________ SUBSCRIBER DOB _______________________
EMPLOYER ____
INSURANCE COMPANY ____
SUBSCRIBER ID ______________________________ GROUP# _______________________________

Please complete both sides of this form. Thank You!