PATIENT INFORMATION

Patient Information:

Today's Date:________________________________

Patient:____ Referred By: ____

Address:____ City:________________________ State:_________ Zip:_______________

Home Phone:______________________ Mobile Phone:______________________ Email: ___________________________________

SS#:________________________________ Date of Birth:________________________________ Age:____________ Sex:___________

Single:____ Married:____ Divorced:____ Separated:____ Widowed:____

If a Minor, Parent or Guardian's Name:____

Party Responsible for Payment:____

Address:____ Phone:_______________________________

City:____ State:_________________________ Zip:_______________________________

Employer:____ Business Phone:___________________________________

Occupation:____

Emergency Contact:____ Relationship:____________________________________

Phone:______________________________________

Insurance Information:

Name of Insured:____ Relationship to Patient:___________________________________

Insured's Date of Birth:_____________________________________ SS#:____

Name of Employer:_______________________________ Ins. Co. ________________________ Phone:________________________

ID#:____ Group #:____

Do you have additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Insured:____ Relationship to Patient:___________________________________

Insured's Date of Birth:____ SS#:____

Name of Employer:_______________________________ Ins. Co. ________________________ Phone:________________________

ID#:____ Group #:____

*Please present your dental insurance card(s) and driver's license to the front desk so that we may keep a copy in your file.

I understand and agree that (regardless of my insurance status) I am responsible for the balance of my account, and payment will be necessary at the time service unless previous financial arrangements have been made.
I have read the above information and certify that the answers provided are correct to the best of my knowledge. I agree to notify the office of any changes to my personal information and/or medical and dental history.

Signature: ____ Date: _________________________