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: _____