

ACCOUNT # \_\_\_\_\_

PATIENT # \_\_\_\_\_

INS. CARRIER # \_\_\_\_\_

Office use only

**Patient Information** Email Address!

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle Nickname

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ S.S.# \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_ Friend \_\_\_\_\_ Neighbor \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Advertising \_\_\_\_\_ Other \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle Marital Status

Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Last First Middle

Spouse's Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes:

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

Complete Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PARENT'S SIGNATURE IF MINOR) \_\_\_\_\_

UPDATES (DATE & INITIAL) \_\_\_\_\_