Family · Cosmetic · Implant

PATIENT INFORMATION

This appointment is for ☐ Yourself ☐ Your Child

Patient Full Name _____ **Social Security #** _____

Birth Date _____ Age _____ ☐ Male ☐ Female _____

Address _____ City _____ State ____ Zip _____

Full Time Student _____ ☐ Yes ☐ No School Name _____

Employer _____ Occupation _____

Previous Dentist _____ Previous Dentist Phone _____

Current Physician _____ Current Physician Phone _____

TELEPHONE & EMAIL

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Home Phone _____ Work Phone _____

RESPONSIBLE PARTY

Who is responsible for this patient

Full Name _____ **Social Security #** _____

Are you ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth Date _____ Age _____ ☐ Male ☐ Female _____

Address _____ City _____ State ____ Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

INSURANCE INFORMATION

Dental Coverage ☐ Yes ☐ No

Insured's Name _____ **Relation** _____

Insured's Social Security # _____ **Birth Date** _____

Insured's Employer _____

Insurance Group # _____ **Insurance Policy #** _____

Insurance Co. Name _____ **Insurance Co Phone** _____

SECONDARY INSURANCE

Insured's Name _____ Relation _____

Insured's Social Security # _____ Birth Date _____

Insured's Employer _____

Insurance Group # _____ Insurance Policy # _____

Insurance Co. Name _____ Insurance Co Phone _____