PATIENT INFORMATION

Patient Name: ____
Last Name First Name Initial
Mailing Address: ____
City: ____________________ State: __________ Zip: ______________
Home Phone: ____________________ Cell Phone: ____________________
Work Phone: ____________________
Sex: M ☐ F ☐ Age: ________ Birthdate: ______________
Patient Employed by: ______________________________________
Occupation: ______________________________________
Business Address: ______________________________________
City: ____________________ State: __________ Zip: ______________
Business Phone: ____________________
Notify in case of emergency: ______________________ Relationship to Patient: __________
Home Phone: ____________________ Cell Phone: ____________________
Business Phone: ____________________

FINANCIAL INFORMATION

Person Responsible for Account: ______________________________________
First Name Last Name
Relationship to Patient: ____________________
Birthdate: ____________________ Social Security #: ____________________
Address (if different than patient): ______________________________
City: ____________________ State: __________ Zip: ______________
Home Phone: ____________________ Cell Phone: ____________________
Work Phone: ____________________
Person Employed by: ______________________________________
Occupation: ______________________________________
Business Address: ______________________________________
City: ____________________ State: __________ Zip: ______________

INSURANCE PRIMARY - Please bring card if available. Dental ☐ Medical ☐

Insured's Name: ____________________ Relationship to Patient: ______________
Insured's ID or SS#: ____________________ Birthdate: ____________________

You only need to complete the following if you do not give us an insurance card.
If you do not have this information, please call your general dentist or the insured's employer.

Name of Insurance Company: ______________________________
Phone Number: ______________________________________

INSURANCE SECONDARY - Please bring card if available. Dental ☐ Medical ☐

If you do not have this information, please call your general dentist or the insured's employer.

Insured's Name: ____________________ Relationship to Patient: ______________
Insured's ID or SS#: ____________________ Birthdate: ____________________

You only need to complete the following if you do not give us an insurance card.
Name of Insurance Company: ______________________________
Phone Number: ______________________________________