PATIENT INFORMATION

Today's Date ______________________________

Salutation: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First Name______________________________

Last Name______________________________

Middle Name______________________________

Preferred Name______________________________

Mailing Address______________________________

City________________ State_____ Zip_________

Birthdate____/____/_____ SSN________________

Home (______) ________________ ☐ Best contact

Work (______) ________________ ☐ Best contact

Cell (______) ________________ ☐ Best contact

Email Address ______________________________

Employer______________________________

Occupation ______________________________

Referring Dentist ______________________________

RESPONSIBLE PARTY

(Parent or Legal Guardian)

First Name______________________________

Last Name______________________________

Billing Address______________________________

City________________ State______ Zip________

Phone Number (______) ______________________

Birthdate____/____/_____ SSN________________

Relationship______________________________

DENTAL PLAN INFORMATION

PRIMARY DENTAL

Insurance Co. Name______________________________

Employer______________________________

Policyholder Information

☐ **CHECK IF SAME AS PATIENT**

Policyholder Name______________________________

Ins. ID and/or SSN______________________________

Birthdate___/___/____ Relationship______________

SECONDARY DENTAL

Insurance Co. Name______________________________

Employer______________________________

Policyholder Information

☐ **CHECK IF SAME AS PATIENT**

Policyholder Name______________________________

Ins. ID and/or SSN______________________________

Birthdate___/___/____ Relationship______________

EMERGENCY CONTACT

Name______________________________

Phone Number (____) ______________________

Relationship to patient______________________

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