



**Patient Information**

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

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

Home Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

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

Dentist \_\_\_\_\_ Physician \_\_\_\_\_ 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 \_\_\_\_\_

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

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

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # Years Employed \_\_\_\_\_

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

Spouse's Employer \_\_\_\_\_ # Years Employed \_\_\_\_\_

Occupation \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Work Phone \_\_\_\_\_

**Insurance Information**

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

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

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

Do you have dual coverage Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:  
 Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

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

Insurance Co. Address \_\_\_\_\_ Insured's Employer \_\_\_\_\_

**Emergency Information**

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

Complete Address \_\_\_\_\_ Phone \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor) \_\_\_\_\_