

PATIENT INFORMATION

Patient Information:

Name: _____ Preferred Name: _____
Birth Date _____ SSN# _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ E-Mail Address: _____

Preferred Pharmacy: _____

Check Appropriate Box:

Child Single Married Divorced Widowed Other

If applicable, Name of Spouse / Partner _____

Emergency Contact:

Name: _____ Phone # _____

Responsible Party (FILL OUT FOR MINORS ONLY)

Name of Person Responsible for this Account: _____
Relationship to Patient: _____
SSN# _____ Birthdate: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Work Phone: _____

Dental Insurance Information:

Name of Insured: _____
Relationship to Patient: _____
Birthdate: _____ SSN# _____
Employer: _____ Work Phone: _____
Insurance Company: _____ Member ID # _____
Ins. Co. Address: _____
Group # _____ Union or Local # _____

DO YOU HAVE *ADDITIONAL* DENTAL INSURANCE YES No IF YES, COMPLETE THE FOLLOWING

Name of Insured: _____
Relationship to Patient: _____
Birthdate: _____ SSN# _____
Employer: _____ Work Phone: _____
Insurance Company: _____ Member ID # _____
Ins. Co. Address: _____
Group # _____ Union or Local # _____

Signature: _____ Date: _____
