

### Patient Information

Date \_\_\_\_\_

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

Address \_\_\_\_\_  
Street City State ZIP

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

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

Whom may we thank for referring you to our office? \_\_\_\_\_

### Responsible Party Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State ZIP

Mailing Address \_\_\_\_\_  
Street City State ZIP

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs) \_\_\_\_\_  
Street city State ZIP

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

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Last First Middle Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### Dental Insurance Information

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

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Insured Birthdate \_\_\_\_\_

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

Insured's Employer \_\_\_\_\_ Insured's Address \_\_\_\_\_  
(if not shown above)

Do you have dual coverage? Yes  No  If yes:

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

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Insured Birthdate \_\_\_\_\_

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

Insured's Employer \_\_\_\_\_ Insured's Address \_\_\_\_\_  
(if not shown above)

### 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) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_