PATIENT INFORMATION

Date: _____

Name: _____ ☐ Male ☐ Female *I prefer to be called*: _____
Mr. Mrs. Ms. Dr.

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Birth Date: ___/___/___ Age: _____ SS#: _____

Home Address: _____ Home Phone: _____
Street City State Zip

Email Address: _____ Cell Phone: _____ Work Phone _____

Employer: _____ Occupation: _____How long there? _____

When and how is the best time to reach you? ☐ Morning ☐Afternoon ☐Anytime ☐Home ☐Cell ☐Work ☐Email

If a full time student, name of school: _____

Spouse's Name: _____ Daytime phone: ____ _____ Birth Date: ____/____/____

Employer: _____ Work Phone: _____

Whom may we thank for referring you? ☐Family or Friend _____

☐Website ☐Internet Search (Google, etc) ☐Mailer ☐School/Work ☐Other _____

PERSON RESPONSIBLE FOR ACCOUNT

If you have dental insurance under someone else, please provide this information for the policy holder.

Name: _____ Relationship to Patient: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Birth Date: _____ Email: _____

Employer: _____ Address: _____
Street City State Zip

INSURANCE INFORMATION – Please provide insurance card to Front Office

**Your name, address, phone number, email address, SSN and any other information you provide are held in strict confidence. We do not sell or share your information with anyone else.

For Office Use Only:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____