DENTAL INFORMATION FORM Dr._____ Acct # _____
Please print clearly… Dr._____ Acct # _____

PATIENT INFORMATION

Patient Last Name: _____First: _____ MI: ____ (Preferred Name? _____)
Mailing Address: _____
Physical Address: _____
City: _____ State: _____Zip Code: _____
Home Number: _____Cell Number: _____Work Number: _____Ext:_____
Email Address: _____
Employer: _____Occupation: _____If student, what school: _____
Birth Date: _____Sex: _____Social Security Number: _____
Marital Status: _____Spouse's Name: _____Spouse's Phone Number: _____

RESPONIBLE PARTY INFORMATION

Parent/ Guardian's Name: _____ SSN: _____ Birth Date: _____
Parent/ Guardian's Employer: _____Work Number: _____ Ext: _____

Parent/ Guardian's Name: _____ SSN: _____ Birth Date: _____
Parent/ Guardian's Employer: _____Work Number: _____ Ext: _____

INSURANCE INFORMATION

Insurance Company Name: _____ Group Number: _____
Address: _____Phone Number: _____
City: _____State: _____Zip Code: _____
Policy Holder's Last Name: _____First: _____MI: ____
SSN:_____ Employer: _____
Birth Date:_____ Patient's Relationship to Policy Holder: _____
Do you have secondary dental insurance coverage? _____If yes, please notify the front desk and provide a completed insurance claim form and/or an insurance identification card.

MISC. INFORMATION

Whom may we thank for referring you to our office? _____
Who is financially responsible for your dental bill? _____
Name of relative not living with you: _____ Phone Number: _____
Name of friend not living with you: _____ Phone Number: _____

Whom may we contact in the unlikely event of an emergency?
Name: _____ Relationship: _____
Home Number: _____ Cell Number: _____ Work Number_____ Ext: ____

By signing below I verify the above information is true to the best of my knowledge.

X _____Date: _____