



PATIENT INFORMATION

DATE: _____

LAST NAME		FIRST NAME		NICKNAME		SS#		SEX	BIRTHDATE	AGE
MAILING ADDRESS				CITY		STATE	ZIP		HOME PHONE	
SCHOOL (IF STUDENT)		GRADE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED	EMPLOYED BY/OCCUPATION			BUSINESS PHONE/CELL PHONE		
WHO MAY WE THANK FOR RECOMMENDING US?				NAME OF DENTIST				DATE OF LAST VISIT		
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE										

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME			RELATIONSHIP TO PATIENT			EMPLOYED BY/OCCUPATION				
MAILING ADDRESS				CITY		STATE	ZIP		HOME PHONE	
CELL PHONE		BUSINESS PHONE		SS#			E-MAIL ADDRESS			

DENTAL INSURANCE INFORMATION

PRIMARY INSURED'S NAME _____					SOC. SEC. # _____				
INSURANCE COMPANY NAME _____					INSURED'S BIRTHDATE _____				
INSURANCE PHONE NUMBER _____					GROUP NUMBER _____				
INSURANCE ADDRESS _____									
2ND INSURED'S NAME _____					SOC. SEC. # _____				
INSURANCE COMPANY NAME _____					INSURED'S BIRTHDATE _____				
INSURANCE PHONE NUMBER _____					GROUP NUMBER _____				
INSURANCE ADDRESS _____									

EMERGENCY CONTACT INFORMATION

CONTACT PERSON IN CASE OF EMERGENCY _____									
PHONE NUMBER _____					RELATIONSHIP _____				