



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"/> SEPARATED	EMPLOYED BY/OCCUPATION			BUSINESS PHONE/CELL PHONE			
		<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED							
WHO MAY WE THANK FOR RECOMMENDING US?				NAME OF DENTIST			DATE OF LAST VISIT			
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE										

PARENT/GUARDIAN INFORMATION

FATHERS NAME _____	MOTHERS NAME _____
ADDRESS (IF DIFFERENT FROM PATIENT'S) _____	ADDRESS (IF DIFFERENT FROM PATIENT'S) _____
CITY _____ ST _____ ZIP _____	CITY _____ ST _____ ZIP _____
EMPLOYER _____	EMPLOYER _____
ADDRESS _____	ADDRESS _____
CITY _____ ST _____ ZIP _____	CITY _____ ST _____ ZIP _____

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			
IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?			MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT?				YES	NO

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 _____