Patient Information

Last Name: _____ M_____ First Name _____
Preferred Name:_____ Home phone: (_____)_____
Address: _____ City:_____
State: _____ Zip: _____ Gender: M ○ F ○ Unknown ○
Marital Status: Single ○ Married ○ Child ○ Widowed ○ Divorced ○
Driver's License No._____ State:_____
Birth date:_____ Soc. Security #:_____
Email: _____
Wireless Phone: (_____)_____ **Would you like to receive Text Messaging :**
. ○ ○ ○ ○ ○ **YES** ○ **NO**

Occupation: _____ Employer:_____
Bus. Address: _____ City:_____
State: _____ Zip: _____ Work phone: (_____)_____
Preferred Contact Method: Do not call ○ Home ○ Work ○ Cell ○ Email ○ Text Message ○

Referred by:_____
Spouse's Name: _____ _____ _____
Why did you come to our office?_____
Person to contact in case of emergency _____
Relationship_____ Phone (_____)_____
Name of person financially responsible for patient _____
Billing address _____
_____

Dental Insurance Information

Insured's name _____
Birth date:_____ Soc. Security #:_____
Address_____
Relationship to Subscriber: Self ○ Spouse ○ Child ○ Life Partner ○ Other_____
Insurance Co. _____ Phone (_____)_____
Insurance Co. Address: _____ City:_____
State: _____ Zip: _____ Group No. _____
Do you have dual coverage? Yes ○ No ○ If yes: Please complete the following secondary insurance information
Insured's name _____Insured's Soc. Sec. # _____
Birth date:_____ Insurance Company _____
Ins Co Address _____
Group No. _____

Patient's Initials_____