Patient Information

Please Print

Title:_____ First Name: ______________________ Middle: ______________ Last: ________________________

Preferred Name: ______________________________ Marital Status: ______________________________

Address: __________________________________ City: ______________ State: _____ Zip: ________

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

Patient Social Security #: ________________ Patient Date of Birth: ______________ Sex: **M** **F**

Email Address: ______________________________________ May we contact you by email? **Yes** **No**

Emergency Contact: ______________________________________ Phone: ______________________

How did you hear about us? ____

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent / Guardian Name: ____

Date of Birth: ____________________ Social Security #: ______________________

Insurance Information

Do you have Dental Insurance? **Yes** **No**

Primary Insurance	**Secondary Insurance**
Subscriber Name: ______________________	Subscriber Name: ______________________
Subscriber SSN: ______________________	Subscriber SSN: ______________________
Date of Birth: ______________________	Date of Birth: ______________________
Relationship to Subscriber:	Relationship to Subscriber:
Self **Spouse** **Child** **Other**	**Self** **Spouse** **Child** **Other**
Employer Name: ______________________	Employer Name: ______________________
Employer Phone: ______________________	Employer Phone: ______________________
Insurance Company: ______________________	Insurance Company: ______________________
Insurance Group # ______________________	Insurance Group # ______________________
Insurance Phone # ______________________	Insurance Phone # ______________________
Insurance Address: ______________________	Insurance Address: ______________________

Please present insurance card and Drivers License