PATIENT INFORMATION:

Patient Name: (Last) _____ (First) _____ (Middle) _____ ☐ **Male** ☐ **Female**

Date of Birth:_____ **Social Security #:**_____ **Height:**_____ **Weight:**_____

Address: (Street) _____ (City) _____ (State) _____ (Zip)_____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Place of Employment:_____ **Occupation:**_____

Marital Status: (Circle one) *Single* *Married* *Divorced* *Widowed* Spouse's Name:_____

Closest Relative:_____ **Relative Phone:**_____

Last Physical Exam:_____ **Name of Physician:**_____

Pharmacy of choice:_____

APPOINTMENT NOTIFICATION:

Would you prefer confirmation and appointment reminders by: (Circle Choices) ***Mail & Phone*** &/or ***E-Mail*** &/or ***Text***
E-Mail address if requesting E-Mail notification: _____

DENTAL INSURANCE INFORMATION:

Relationship to the patient: (Circle one) *Self* *Spouse* *Child* *Other*

Name of insured Party: (Last) _____ (First) _____ (Middle)_____

Insured's Social Security Number: _____ **Insured's Date of Birth:** _____

Insured's Address: _____ (City) _____ (State) _____ (Zip)_____

Insured's Phone Number: (Cell) _____(Home) _____ (Work) _____

Insured's Employer: (Name) _____ (Address) _____

Insurance Member ID: _____ **Group Number:** _____

Signature of Parent/Person Completing Form:_____**Date:**_____

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