



# Patient Information

Please complete this form in ink and print your answers.  
If you have any questions, please do not hesitate to ask one of our staff.

Name \_\_\_\_\_ Date \_\_\_\_\_  
First Name MI Last Name

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_  Male  Female Home Phone# (\_\_\_\_) \_\_\_\_\_

Cell Phone# (\_\_\_\_) \_\_\_\_\_ Work Phone# (\_\_\_\_) \_\_\_\_\_

Where do you prefer to take calls:  Home  Cell  Work

May we contact you by E-mail?  Yes  No E-mail Address \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Workplace \_\_\_\_\_

If you are a student, name of school \_\_\_\_\_ City/State \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Closest relative not living with you & their phone number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_

**Responsible Party** *(if patient is a minor)*

Name of person financially responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Address of Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Information**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber Birthdate \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone # (\_\_\_\_) \_\_\_\_\_

Do you have additional dental insurance?  Yes  No If yes, Please complete the following:

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone # (\_\_\_\_) \_\_\_\_\_