Patient Information

Date_____

Patient Name_____
Last Name First Name

Preferred Name_____

Responsible Party Name _____

Address_____

City_____State_____Zip_____

Sex M__ F__ Birthdate_____

Soc Sec #_____-_____-_____Driver Lic #_____

Home # (_____) Work # (_____) Ext____

Cell #_(_____)_____

Would you like text message reminders for your appointments
Yes_____ No_____

Email_____

Would you like Email reminders for your appointments
Yes_____ No_____

Marital Status:

Married___ Single___ Divorced___ Separated___ Widowed___

Patient Employer_____

Occupation_____

Employers # (_____)_____

Whom may we thank for referring you?_____

Emergency Contact

Name_____Relationship_____

Best number to reach them (_____)_____

Dental Insurance

Primary Insurance Information

Name of Insured_____

Relationship to Patient_____

Insured Soc Sec #_____-_____-_____

Insured Birthdate_____

Insurance Company_____

Member ID #_____

Group #_____

Employer Name_____

Ins. Company Address_____

City_____State_____Zip_____

Phone # (_____)_____

Secondary Insurance Information

Name of Insured_____

Relationship to Patient_____

Insured Soc Sec #_____-_____-_____

Insured Birthdate_____

Insurance Company_____

Member ID #_____

Group #_____

Employer Name_____

Ins. Company Address_____

City_____State_____Zip_____

Phone # (_____)_____