PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient

Name: ______________________________ M / F __

Nickname: ______________________________

Address: ______________________________

City: ____________ State: ______ Zip: ______

Home Phone #: ______________________________

Birthday: ______________________________

SSN: ______________________________

Single Married Widowed Separated

If Student, School?: ______________________________

Employer: ______________________________

Occupation: ______________________________

Employer Address: ______________________________

City: ____________ State: ______ Zip: ______

Work Phone #: ______________________________

When & Where Is The Best Time To Reach You?: __

____

Cell Phone #: ______________________________

Email: ______________________________

Preferred Method of Contact: ______________________________

Dental Insurance

Primary Insurance Co. : ______________________________

Address: ______________________________

City: ____________ State: ______ Zip: ______

Phone #: ______________________________

Group / Plan / Policy #: ______________________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Birthday: __________ SSN: ______________

Employer: ______________________________

Secondary Insurance Co. : ______________________________

Address: ______________________________

City: ____________ State: ______ Zip: ______

Phone #: ______________________________

Group / Plan / Policy #: ______________________________

Insured's Name: ______________________________

Relationship to Patient: ______________________________

Birthday: __________ SSN: ______________

Employer: ______________________________

Spouse or Parent

Mother / Wife's Name: ______________________________

Step Parent Guardian

Address: ______________________________

Employer: ______________________________

Occupation: ______________________________

Employer's Address: ______________________________

Work Phone #: ____________ SSN: ____________

Father / Husband's Name: ______________________________

Step Parent Guardian

Address: ______________________________

Employer: ______________________________

Occupation: ______________________________

Employer's Address: ______________________________

Work Phone #: ____________ SSN: ____________

Getting To Know You

Is another member of your family, or relative a patient at our office? ______________________________

____

Who told you about our office?: ______________________________

____

Person to contact for emergency: ______________________________

____

Address: ______________________________

Phone #: ______________________________

Relationship: ______________________________

Closest relative not living with you:

____

Address: ______________________________

Phone #: ______________________________

Relationship: ______________________________