

**Patient Information**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_

Name of patients General Dentist \_\_\_\_\_

Whom may we thank for referring you to our office \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City Zip

E-Mail \_\_\_\_\_ Cell # \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ WorkPhone ( ) \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_

Phone \_\_\_\_\_ Street City Zip  
Date \_\_\_\_\_

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & Initial) \_\_\_\_\_