



# Patient Information

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

[ ] Male [ ] Female Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_

Email address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

If a child, give parent's or guardian's name \_\_\_\_\_ SS# \_\_\_\_\_

**Responsible Party Information (if different from above)**

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

Address \_\_\_\_\_ Birth Date \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Last First Middle

Insurance company name and phone # \_\_\_\_\_

Dental Insurance Address \_\_\_\_\_  
Street City State Zip

Insured's Employer \_\_\_\_\_

Do you have dual coverage? [ ] No [ ] Yes **If Yes, complete the following:**

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Last First Middle

Dental Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_  
Street City State Zip

**Emergency Notification Information**

In case of emergency, who should be notified?

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Referral Information (who can we thank)**

Name \_\_\_\_\_

To the best of my knowledge, all the preceding answers are true & correct. \_\_\_\_\_

Signature of Patient or Guardian

Date