# PATIENT INFORMATION

(Please print legibly, in black or blue ink)

| | | |
|---|---|---|
| Patient's Last Name | | Date |
| Legal First Name | | Middle Initial |
| What would you prefer to be called? | | |
| Marital Status: Married Single Child Other | | |
| Date of Birth | | Sex: Male Female |
| Social Security Number | | |
| Home Address | | |
| | | |
| City | State | Zip |
| E-Mail Address | | |
| Home Phone<br>( ) | Cell Phone<br>( ) | |
| Employer/Occupation | | |
| Work Phone<br>( ) | Fax<br>( ) | |
| Where do you prefer to be contacted? (please number in order of preference)<br>____Home ____Work ____Cell ____E-mail ____Fax<br>May we text? Y / N | | |
| Whom may we thank for referring you here? | | |
| Who is your general dentist? | | |
| What is his/her phone number or office location? | | |
| Who is responsible for payment on this account? | | |

**Please continue on reverse side**.

| EMERGENCY CONTACT | | |
|---|---|---|
| Last Name | First Name | |
| Relationship to Patient | | |
| Phone Number<br>(  ) | | Extension |

## PRIMARY DENTAL INSURANCE

| | | | |
|---|---|---|---|
| Who is the policy holder? | | | |
| Insurance Carrier Name | | | |
| Subscriber's Employer/Group Plan Name | | | |
| Group Number | Subscriber's Date of Birth | | |
| Subscriber ID (or Social Security No.) | | | |
| How are you related to subscriber? | Self | Spouse | Dependent |

## SECONDARY DENTAL INSURANCE

| | | | |
|---|---|---|---|
| Who is the policy holder? | | | |
| Insurance Carrier Name | | | |
| Subscriber's Employer/Group Plan Name | | | |
| Group Number | Subscriber's Date of Birth | | |
| Subscriber ID (or Social Security No.) | | | |
| How are you related to subscriber? | Self | Spouse | Dependent |