Patient Information

Welcome to our office, please provide us with information requested below. All information is kept confidential.

Patient's Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: M/F Soc. Sec. #:_____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Driver's License #: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ (circle one) Married, Single, Divorced, Widowed

Spouse's Name: _____ Spouse's Work Phone: _____

Responsible Party's Name: _____ Phone: _____
(If Patient is Under Age 18)

Referring Dentist: _____ Physician: _____

Reason for Visit: _____

Insurance Information

Name of Insured: _____ Soc. Sec. # _____

Relationship to Insured: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Insurance: _____ Group #: _____

Employer: _____ Phone #: _____

Signature of Patient or Responsible Party: _____