

Date \_\_\_\_\_

# Patient Information (Confidential)

A B C

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle I. (Nickname)

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

Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_

If patient is a minor, give parents or guardians name \_\_\_\_\_ Family Dentist \_\_\_\_\_

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

## Responsible Party Information

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_ E-mail \_\_\_\_\_  
Street City State Zip

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

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

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

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone \_\_\_\_\_

## DENTAL Insurance Information Only

Policy Holder's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

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

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

**Bold print for office use only**

Effective Date: Waiting Period \_\_\_\_\_ Age Limit \_\_\_\_\_ Lifetime Max \_\_\_\_\_ % Deductible \_\_\_\_\_

Used \_\_\_\_\_ Initial Pmt \_\_\_\_\_ Submit: once - Monthly - Qrtly Insurance pays: **Monthly - Qrtly**

Payment to: **Patient Doctor AOB POC at Insurance Company** \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Policy Holder's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

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

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Effective Date: Waiting Period \_\_\_\_\_ Age Limit \_\_\_\_\_ Lifetime Max \_\_\_\_\_ % Deductible \_\_\_\_\_

Used \_\_\_\_\_ Initial Pmt \_\_\_\_\_ Submit: once - Monthly - Qrtly Insurance pays: **Monthly - Qrtly**

Payment to: **Patient Doctor AOB POC at Insurance Company** \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

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

Updates (date & initial) \_\_\_\_\_