NAME: _____ **DATE:** _____
first middle last ❒Mr. ❒Mrs. ❒Ms. ❒Dr.

Nickname: _____ ❒Male ❒Female

Birthdate:_____/_____/_____ Age:_____

SS# _____

❒Single ❒Married ❒Divorced ❒Widowed ❒Separated

Home Address:_____

_____
City State Zip Code

Home #: _____ Cell #: _____

Work # _____ Ext:_____

Employer:_____

Employer Address: _____

_____

Occupation: _____

Who may we thank for referring you? _____

Other family members seen by us: _____

_____

Previous dentist: _____

Last visit date: _____

SPOUSE INFORMATION

Name: _____

Birthdate:_____/_____/_____ Age:_____

Employer:_____

Work # _____ Ext:_____

Home #: _____ Pager/Other #: _____

EMERGENCY CONTACT- other than spouse
(nearest relative/friend residing at different address):

Name: _____

Address: _____

_____
City State Zip Code

Phone #: _____ Relationship _____

PRIMARY DENTAL INSURANCE

Insurance Company: _____

Claims Address: _____

_____

Phone #: _____

Group or Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate:_____/_____/_____

SS#: _____

Insured's Employer:_____

SECONDARY INSURANCE

Insurance Company: _____

Claims Address: _____

_____

Phone #: _____

Group or Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate:_____/_____/_____

SS#: _____

Insured's Employer:_____

RESPONSIBILITY FOR FEES

I understand that I am responsible for payment of all fees for dental services provided on my behalf and such payment is due in full at the time of service unless prior arrangements have been made. I understand that submission of dental claims to my insurance company is a courtesy and I am responsible for fees not covered by insurance.

_____
Signature Date