PATIENT INFORMATION

Name Date of Birth

Sex (Please circle) Male Female Marital Status (Please circle) Single Married Divorced Widowed

Street Address

City State Zip Code

Home Phone # Mobile #

Social Security # Driver's License #

Email Address

Employer Employer Phone #

Employer Address

PARENT OR GUARDIAN INFORMATION (To be completed if patient is under the age of 18 or has a legal guardian)

Name

Date of Birth Social Security #

Home Phone # Mobile #

Employer Employer Phone #

DENTAL INSURANCE INFORMATION (Please provide a copy of your dental card)

Policyholder Name Date of Birth

Relationship to Patient

Policyholder ID # or SS # Group #

Insurance Company Name & Phone #

Secondary Insurance Please ask for additional sheet if you have a secondary dental insurance plan.

EMERGENCY CONTACT/SPOUSE INFORMATION

Emergency Contact Name & Phone #

Spouse Name & Phone # if not listed as your Emergency Contact above.

I CONSENT TO BEING CONTACTED BY THE FOLLOWING METHODS BUT PREFER THE CIRCLED CHOICE(S)

Phone call Text message E-mail

Signature **Date**