



Patient Information

Patient's Name _____ Birth Date ___ / ___ / ___
 Address _____ City _____ State _____ Zip _____
 Patient's email _____ Patient's Dentist _____
 Whom may we thank for referring you? _____

Custodial & Responsible Party Information

Name _____ Marital Status _____
 Mailing Address _____ City _____ State _____ Zip _____
 How long at this address _____ Home Phone _____ Work Phone _____
 Cell Phone _____ Responsible Party email address: _____
 Previous Address (if less than 3 years) _____
 Soc. Sec. # ___ - ___ - ___ Birth Date ___ / ___ / ___ Relationship to Patient _____
 Employer _____ Occupation _____ No Years Employed _____
 Spouse's Name _____ Relationship to Patient _____
 Spouse's Soc. Sec. # ___ - ___ - ___ Spouse's Birth Date ___ / ___ / ___
 Spouse's Employer _____ Occupation _____ No Years Employed _____

Insurance Information

Primary Insured's Name _____ DOB ___ / ___ / ___ Member ID or Insured's Soc Sec. # _____
 Insurance Company _____ Toll Free Phone# _____
 Insurance Co. Address _____
 Do you have dual coverage? **Yes** **No** (Usually whoever has the 1st birthday **in the year** is the primary insurance)
Secondary Insured's Name _____ DOB ___ / ___ / ___ Member ID or Insured's Soc. Sec. # _____
 Insurance Company _____ Toll Free Phone# _____
 Insurance Co. Address _____

Emergency Information

Name of nearest relative **not** living with you _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Relationship to Patient _____
 Signature (Parent's signature, if Minor) _____ Date ___ / ___ / ___
 I understand that where appropriate, credit bureau reports may be obtained. _____ (Initials)