



**Patient Information**

Name \_\_\_\_\_ Home phone \_\_\_\_\_  
 Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Zip \_\_\_\_\_ E-mail \_\_\_\_\_  
 SS# \_\_\_\_\_ Birth Date \_\_\_\_\_

Single       Married       Partnered       Separated       Divorced

Whom may we thank for referring you? \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone number \_\_\_\_\_

**Responsible Party**

Are you the person financially responsible for this account? Yes  No

Driver's license # of person financially responsible for this account: \_\_\_\_\_

**Insurance Information**

Name of employer \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Are you the primary holder on the above insurance? Yes  No

If No, what is the name of the Primary holder \_\_\_\_\_ Primary's Birth date \_\_\_\_\_

SS # of the Primary holder \_\_\_\_\_

Do you have additional dental insurance? \_\_\_\_\_ Insurance company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

X \_\_\_\_\_  
**Signature of Patient or Parent/Guardian if minor** **Date**