Dentistry by
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Section I: Patient Information **Date_____**

Name:_____

I Prefer to be called: _____

Gender: ☐ Female ☐ Male Date of Birth:_____-_____-_____ SSN#_____

Address:_____

City:_____State:_____Zip_____

Home Phone (_____)_____ Work Phone (_____) _____ Cell Phone(_____)_____

Preferred method of contact: _____

Email Address_____

May we contact you by email? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

If you are under 18 years of age:

Section II Responsible Party

Name:_____ Relationship to Patient: _____

Address:_____

City:_____ State:_____ Zip:_____

SSN#_____ Home Phone (_____)_____

Work Phone (_____)_____Cell Phone (_____)_____

If you have insurance benefits:

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____Name of Employer:_____

Insurance Company_____ Grp #_____ ID#_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____Name of Employer:_____

Insurance Company_____ Grp #_____ ID#_____