



"...Relax and Treat Yourself to the Dentistry You Deserve"

About You

Today's Date: _____ E-mail: _____
Name: _____ I prefer to be called: _____
Male / Female Birth Date: ___/___/_____ Age: _____ Social Security #: _____-_____-_____
Please circle one: Single / Married / Divorced / Widowed / Separated
Home Address: _____
Street & Apartment Number City State Zip
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Ext: _____
Where and When are best times to reach you? _____
Who may we thank for referring you? _____
Other family members seen by us: _____
Employer: _____ How long? _____ Occupation: _____
Employer's Address: _____

Emergency Contact person

Name: _____ Relation: _____
Work Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Responsible Party Information

Name: _____ Relation: _____
Work Phone #: (____) _____ - _____ Home Phone #: (____) _____ - _____
Home Address: _____
Street & Apartment Number City State Zip

Primary Dental Insurance Information

Insurance Company: _____ Phone #: (____) _____ - _____
Group #: (Plan, Local or Policy #): _____ Effective Date: _____
Insurance Co. Address: _____
Insured's Name: _____ Insured's Social Security #: _____-_____-_____
Insured's Birthdate: ___/___/_____ Relationship to patient: _____
Insured's Employer: _____
Employer's Address: _____

Secondary Dental Insurance Information

Insurance Company: _____ Phone #: (____) _____ - _____
Group #: (Plan, Local or Policy #): _____ Effective Date: _____
Insurance Co. Address: _____
Insured's Name: _____ Insured's Social Security #: _____-_____-_____
Insured's Birthdate: ___/___/_____ Relationship to patient: _____
Insured's Employer: _____
Employer's Address: _____

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

Signature of Patient / Parent or Guardian _____ Date _____