PATIENT INFORMATION

Patient Name: ___________________ , ________________ ___ ________________ Date: _______________
Last First MI Preferred

Date of Birth: ________-_______-_________ Social Security #: _______-______-________ Gender: M F
Month Date Year

Address: ____ Email: _______________________________

____ Marital Status: M S D W
City ST Zip

Phone (Cell) _________________ (Home) _________________ (Work) _________________ ext: ________

We notify patients of upcoming appointments via text messages and/or email. Which do you prefer?

Text _____ Email _____ Both _____ Neither, please call _____

RESPONSIBLE PARTY INFORMATION

_____ Patient is responsible for payment (Skip this section)

Name: ___________________ , ________________ ___ Relationship to Patient: _______________________
Last First MI

Date of Birth: ________-_______-_________ Social Security #: _______-______-________ Gender: M F
Month Date Year

Address: ____ Email: _______________________________

____ Marital Status: M S D W
City ST Zip

Phone (Cell) _________________ (Home) _________________ (Work) _________________ ext: ________

DENTAL INSURANCE INFORMATION

_____ Patient does NOT have dental insurance (Skip this section.)

_____ Patient is the subscriber/policy holder _____ Responsible party is the subscriber/policy holder

Insurance Company's Name: _____________________________ Group Number: _______________________

Insurance Company's Address: ____
City ST Zip

Insurance Company's Phone Number: ___________________ Employer: _______________________________

Subscriber's ID Number: _______________________________ (It may be the SSN of the subscriber.)

Please provider a copy of your dental insurance card.