



Patient Information

Please Print

Title: First Name: Middle: Last:

Preferred Name: Marital Status:

Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Patient Social Security #: Patient Date of Birth: Sex: ☐ M ☐ F

Email Address: May we contact you by email? ☐ Yes ☐ No

Emergency Contact: Phone:

How did you hear about us?

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent / Guardian Name:

Date of Birth: Social Security #:

Insurance Information

Do you have Dental Insurance? ☐ Yes ☐ No

Primary Insurance	Secondary Insurance
Subscriber Name: <input type="text"/>	Subscriber Name: <input type="text"/>
Subscriber SSN: <input type="text"/>	Subscriber SSN: <input type="text"/>
Date of Birth: <input type="text"/>	Date of Birth: <input type="text"/>
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name: <input type="text"/>	Employer Name: <input type="text"/>
Employer Phone: <input type="text"/>	Employer Phone: <input type="text"/>
Insurance Company: <input type="text"/>	Insurance Company: <input type="text"/>
Insurance Group #: <input type="text"/>	Insurance Group #: <input type="text"/>
Insurance Phone #: <input type="text"/>	Insurance Phone #: <input type="text"/>
Insurance Address: <input type="text"/>	Insurance Address: <input type="text"/>

Please present insurance card and Drivers License