1. PATIENT INFORMATION

Name of Patient: _____(preferred name)_____
Address: _____
Phone: home:_____ cell:_____ work:_____
Patient date of birth: _____ Patient marital status: _____
Patient Social Security #:_____
Emergency contact:_____

If Patient is employed: Name, address and phone number of employer:
_____
If Patient is a student: full time_____ part time _____ N/A _____
Name, city and state of school or university where patient is enrolled:
_____
Patient's primary care doctor (name and phone #):_____
Preferred pharmacy and phone number:_____

Name & phone # of previous dentist:
_____ Date last seen_____
Purpose of today's visit:
_____

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2. PRIMARY DENTAL INSURANCE INFORMATION

Is the Patient the Policyholder/Subscriber? Yes____ No____
If no, name of primary Policyholder and relationship to Patient
_____
Address/Phone # of Policyholder (if different from Patient):
_____
Policyholder date of birth:_____ Policyholder Social Security #_____
Name, address and phone # of primary dental insurance company:
_____
Name of Policyholder's Employer, group # and/or Policyholder/Subscriber ID #:
_____
Do you have a dental insurance card that we may copy for our records? Yes____ No____

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3. SECONDARY DENTAL INSURANCE INFORMATION (if applicable)

Is the Patient the Policyholder/Subscriber? Yes____ No____
If no, name of secondary Policyholder and relationship to Patient:
_____
Address/Phone # of Policyholder:
_____
Policyholder date of birth: _____ Policyholder Social Security #:_____
Name, address and phone # of secondary dental insurance company:
_____
Name of Policyholder's Employer, group # and/or Policyholder/Subscriber ID #:
_____
Do you have a dental insurance card that we may copy for our records? Yes____ No____

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Signature of Patient/Responsible Party **Date**