Patient Information:

Patient Name: ____

Male: ___ Female:____ Married: _____ Single: _____ Child: _____ Other: ______

Social Security #: __________________________ Date of Birth: _____/____/________

Phone (home) :________________________ (work phone):______________________________

(cell phone): ______________________________ Is it OK to text you reminders? ________________

Email address: ________________________________ OK to email you reminders?___________________

Mailing Address:

Street: ____ apt #_________
City__________________________ State___________________ zip________________

Responsible Party Information:

Patient's spouse? : Y / N Person responsible for payment?: Y / N Guardian? Y / N
Name: ____
Social Security # :___________________________ Date of Birth:_____/____/_______
Phone: (home) ____________________________ (cell phone): _______________________
Mailing address if different than above:

____
____

Emergency Contact information:

Name:____
Relationship to patient:______________________ emergency contact phone #: _________________________________

Insurance Information:

Name of insured: ____ Insured Birth Date: ____/____/________
ID# _______________________________ Group # ____________________ SS#_____________________
Insured's address ____
Insured's employer name: ____
Employer's address: ____
Patient's relationship to insured: Self :_____ Spouse: ______ Child:______ Other:______________
Insurance Plan Name and address:____

____

Secondary Insurance:

Name of insured: ____ Insured Birth Date: ___ /____/________
ID# _______________________________ Group # ____________________ SS#_____________________
Insured's address ____
Insured's employer name: ____
Employer's address: ____
Patient's relationship to insured: Self : _____ Spouse:______ Child:______ Other:______________
Insurance Plan Name and address:____

Referral Information:

Whom may we thank for referring you to our practice? A friend: ________ A relative:______________
Your dental insurance:______ Google/ Internet: _______ Northeaster newspaper: _______ Work:_____
Name of person who recommended us, so we can thank them ☺ ________ __________________________________

Patient, parent, or guardian
Signature: ____ Date: ________