**PATIENT INFORMATION (CONFIDENTIAL)**

Name: ______________________________________________________________ Date: ________________

Address: _____________________________________ City ____________________ State _____Zip _________

E-Mail: ____________________________________ Home Phone: ______________ Cell: _________________

SS #: _________________________ Date of Birth: _________________________

Check appropriate: ___Minor ___Single ___ Married ___Divorced ___ Widowed ___ Separated

If College Student: __ FT __ PT Name of School _____________________________ City ______________ St ____

Employer: (Patient's or parents/guardian) __________________________________________________________

Business Address: ________________________________________________ Work Phone: _______________

Parents' or Guardian's Name: ___________________________________________ Phone #: _______________

Whom may we thank for referring you? ____________________________________________________________

Emergency Contact: ___________________________________________________ Phone #: ______________

**RESPONSIBLE PARTY**

Name of person responsible for this account: _______________________________ Relationship: _____________

Address: ____________________________________________________________________________________

E-Mail: ____________________________________ Home Phone: ______________ Cell: _________________

Driver's License #: ________________________ Birthdate: __________________ SS#: ___________________

Employer: _______________________________________________Work Phone: ______________________

Is this person already a patient in our office? _____ Yes ____No

**INSURANCE INFORMATION**

Name of insured: ____________________________________________Relationship ______________________

SS #: _________________________ Date of Birth: ____________________Work Phone# _________________

Employer name & address ____________________________________________________________________

Ins. Company: ______________________________ Phone #: ___________________ Grp # ________________

Ins. Co. Address: ___________________________________________________________________________

Do you understand your coverage? __yes _No Max Benefit _________ Deductible _________

Do you have any additional dental insurance coverage? ____ Yes ___No

**SECONDARY INSURANCE COVEAGE (if applicable)**

Name of insured: ____________________________________________Relationship ______________________

SS #: _________________________ Date of Birth: ____________________Work Phone# _________________

Employer name & address ____________________________________________________________________

Ins. Company: ______________________________ Phone #: ___________________ Grp # ________________

Ins. Co. Address: ___________________________________________________________________________

Do you understand your coverage? __yes _No Max Benefit _________ Deductible _________