Print Form

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ (First / MI / Last) Today's Date _____

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If College Student, F.T. / P.T., Name Of School _____ City _____ State _____

Patient's Or Parent's Employer _____ Work Phone _____

Spouse Or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank For Referring You? _____

Person To Contact In Case Of An Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible For This Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Work Phone _____

Is This Person Currently A Patient In Our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name Of Policyholder _____ Relationship To Patient _____

Name of Insurance Company _____

Birthdate _____ Soc. Sec. # _____

Name Of Employer _____ Union Or Local # _____

Do You Have Any Additional Insurance? ☐ **Yes** ☐ **No** **If Yes, Complete The Following:**

Name Of Policyholder _____ Relationship To Patient _____

Name of Insurance Company _____

Birthdate _____ Soc. Sec. # _____

Name Of Employer _____ Union Or Local # _____

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

X _____ _____

Signature Of Patient Or Parent If Minor Date

12/03

REORDER #0613711

REGISTRATION