Patient Information (PLEASE PRINT)

Patient's Name:_____ Birth Date:_____ Male or Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Soc. Sec # _____ Driver Lic # _____

Employer: _____ Occupation: _____

Emergency Contact _____ Phone #1 _____ #2 _____

Parent or Responsible Party (If different than Patient)

Name: _____Birth Date_____

Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Soc. Sec # _____ Driver Lic # _____

Employer: _____ Occupation: _____

Primary Dental Insurance Information

Insurance Company: _____ Telephone # _____

Policy Holder's Name: _____ Employer: ____ _____

ID/ Soc. Sec #: _____ Date of Birth: _____ Relation to Patient: _____

Secondary Dental Insurance Information

Insurance Company: _____ Telephone #: _____

Policy Holder's Name: _____ Employer: _____

ID / Soc Sec. # _____ Date of Birth: _____ Relation to Patient: _____

Insurance is filed as a courtesy to our patients. By signing below you are authorizing the release of personal information to your insurance carrier. You are responsible for all fees not paid for by your insurance. Your signature authorizes payment directly to our office of benefits otherwise payable to you.

Signature (Patient, Parent or Guardian) _____ Date _____