patient information

Tell us about the patient:

Date

Patient's first name	Middle initial	Last name		Social Security number
Home address	City	State	Zip code	Home phone

Birthdate	If patient is a minor, give parent's or guardian's name	Whom may we thank for referring you to our office?

Tell us about the party responsible for the patient:

○ If same as above, check here and skip to mailing address	First name	Middle initial	Last name	
Relationship to patient		Birthdate		Social Security number
Home address	City	State	Zip code	Home phone
Mailing address	City	State	Zip code	Email address
Employer		Occupation		Work phone
Spouse's first name	Middle initial	Last name		Spouse's Social Security number
Spouse's employer		Spouse's occupation		Spouse's work phone

Tell us about the patient's dental insurance:

Insured persons' first name	Middle initial	Last name		Insured's Social Security number
Insurance company		Group number		Local number
Insurance company address	City	State	Zip code	Insurance company phone

Do you have additional dental coverage? ○ If NO, check here and skip to emergency contact ○ If YES, check here and fill out the section below

Insured persons' first name	Middle initial	Last name		Insured's Social Security number
Insurance company		Group number		Local number
Insurance company address	City	State	Zip code	Insurance company phone

Tell us who we should contact in case of emergency:

Name of emergency contact				Relationship to patient
Emergency contact's address	City	State	Zip code	Phone

Signature (If patient is a minor, parent's or guardian's signature)

OFFICE USE ONLY: UPDATES (DATE AND INITIAL)