Thank you for selecting our dental health team.

We look forward to working with you in maintaining your dental health.

**Patient Information: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male:\_\_Female:\_\_Single:\_\_Married:\_\_Other:\_\_Minor: Y N

SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver's License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_

Home Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best way to reach you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other family members seen by us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If referred by someone, whom may we thank for the referral?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian information (if patient is a minor):**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date:\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver's License#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip:\_\_\_\_\_

Home Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#:\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Information (Primary):**

Policyholder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policyholders ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Policyholder: Self:\_\_\_\_Child:\_\_\_\_\_Other:\_\_\_\_\_

**Dental Insurance Information (Secondary):**

Policyholder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employeer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policyholders ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Policyholder: Self:\_\_\_\_\_Child:\_\_\_\_\_Other:\_\_\_\_\_

**Medical Insurance Information (Primary):**

Policyholder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policyholders ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Policyholder: Self:\_\_\_\_Child:\_\_\_\_\_Other:\_\_\_\_\_

**Medical Insurance Information (Secondary):**

Policyholder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employeer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policyholders ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Policyholder: Self:\_\_\_\_\_Child:\_\_\_\_\_Other:\_\_\_\_\_