

Date _____

Confidential Patient Information

A B C 10/08

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birth Date _____ Social Security # _____

Patient's Dentist _____ Patient's Doctor _____

If patient is a minor, give **parent's or guardian's** name _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Email address: _____

Residence _____ Own Rent
Street City State Zip

Mailing Address _____ Home Phone _____
Street City State Zip

How long at this address _____ Work Phone _____ Cell Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birth Date _____ Work Phone _____

Dental Insurance Information

Policy Holder's Name _____ and Soc.Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's or guardian's signature if minor) _____

Updates (date & initial) _____