

**Patient Information**

Patient Name \_\_\_\_\_ Legal Name \_\_\_\_\_

Live With: (Self) (Parents) (Spouse) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Sex: ( F ) ( M ) Marital Status: (Single) (Married) (Divorced) (Widowed)

Social Security Number: \_\_\_\_\_

Full Time College Student (Yes) (No) Where: \_\_\_\_\_

Responsible Party For the Account: \_\_\_\_\_

How Did You Hear About The Office: \_\_\_\_\_

**Insurance**

Do You Have Dental Insurance:

(Circle all that apply): Yes No One Company Two Companies

Primary Dental Insurance

Name of Person With Insurance: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

Relationship to Insured Party: ( Self ) ( Spouse ) ( Child ) ( Other )

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

Insurance Company: \_\_\_\_\_

Insurance Identification #: \_\_\_\_\_

Secondary Dental Insurance

Name of Person With Insurance: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

Relationship to Insured Party: (Self) (Spouse) (Child) (Other)

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

Insurance Company: \_\_\_\_\_

Insurance Identification #: \_\_\_\_\_

(Please Complete Other Side)