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)