PATIENT INFORMATION

Patient Name ____ Birth Date ________________

Who referred you to this office? _______________________ Social Security # ____________________

Address _____________________________________ City _____________ ST____ ZIP ____________

___Male ___Female ___Single ___Married ___Child ___Other

Home Phone _____________________ Work Phone _____________________ Ext ____________

Cell Phone ____________________ Pager _________________ E-Mail _______________________

Employer _______________________________ City _____________ Occupation _________________

Name of Spouse / Partner / Parent / Guardian ______________________ Birth Date ______________
(circle one)

Social Security # __________________________

Address if different_____________________________ City__________ ST_____ ZIP ______________

Home Phone ________________________ Work Phone__________________ Ext _____________

Employer _________________________________City ______________ Occupation __________________

In case of emergency, whom shall we notify other than spouse?

Name ________________________ Relationship _____________ Phone ____________________________

PRIMARY INSURANCE INFORMATION

EMPLOYEE NAME ____________________________

INS CO NAME ________________________________

INS CO ADDRESS ____________________________

INS CO CITY, ST, ZIP _________________________

INSURANCE PHONE __________________________

GROUP / POLICY # __________________________

EMPLOYEE SS # _____________________________

SECONDARY INSURANCE INFORMATION

EMPLOYEE NAME ________________________

INS CO NAME ____________________________

INS CO ADDRESS ________________________

INS CO CITY, ST, ZIP _____________________

INSURANCE PHONE ______________________

GROUP / POLICY # ______________________

EMPLOYEE SS # _________________________

Patient Acknowledgments:

- I understand that I am responsible for all fees incurred at the time of service.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic and educational purposes.
- If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.

I have read the above: Signature ____ Date ______________________
Parent or Guardian if a minor