



Patient Information

Date: _____ Birth Date: _____ Social Security #: _____

Name: _____ Sex: M F

How do you prefer to be addressed by the doctor and staff? _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____ Cell Phone /Pager: _____

E-mail: _____ Circle the best method to correspond w/ you: Mail, Home #, Work#, Cell #, E-mail

Patient Employed By: _____ Occupation: _____

Business Address: _____

Spouse's Name (*or* parent's name/information if patient is minor): _____

Spouse Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Local Pharmacy: _____ Address: _____ Phone: _____

Primary General Dentist: _____ Other Dentist/ Specialist seen for routine care _____

Emergency contact/ phone number: _____

Dental Insurance – please provide your insurance card so we can make a photocopy

Subscriber Name: _____ Relation To Patient: _____ Birth Date : _____

Subscriber Employed By: _____ Occupation: _____ Social Security #: _____

Insurance Company: _____ Insurance Co Phone#: _____

Secondary dental insurance coverage:

Subscriber Name: _____ Relation To Patient: _____ Birth Date : _____

Subscriber Employed By: _____ Occupation: _____ Social Security #: _____

Insurance Company: _____ Insurance Co Phone#: _____