

## PATIENT INFORMATION

Patient Name: Dr. Mr. Mrs. Ms. Miss \_\_\_\_\_

By what name do you prefer to be called? \_\_\_\_\_

Birthday: \_\_\_\_\_ Social Security No: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address if different than above: \_\_\_\_\_

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

E-mail Address: \_\_\_\_\_

May we e-mail you about: Appointments? Yes No Special Offers? Yes No Dental Information? Yes No

Name of Employer: \_\_\_\_\_

If full time student, name of school: \_\_\_\_\_

Name of person responsible for account: \_\_\_\_\_

Address/Phone (if different from above): \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Relative Not Living With You: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

## INSURANCE INFORMATION

First Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

Second Insurance Company \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

(PLEASE COMPLETE THE BACK SIDE OF THIS FORM)