

## PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

**Please note: Email/text reminders are for appointment purposes ONLY. We respect your privacy and will never sell your information to any third party.**

### CHECK APPROPRIATE BOX

MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED  MALE  FEMALE  DECLINE TO ANSWER

**WHAT IS YOUR GENDER PRONOUN:**  HE/HIM  SHE/HER  SOMETHING ELSE [DESCRIBE] \_\_\_\_\_  DECLINE TO ANSWER

SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ STATE OF ISSUE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

IF COLLEGE STUDENT, FT/PT, NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

PATIENT OR PARENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

DRIVER'S LICENSE# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE?**  YES  NO **IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to this dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

X \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR

\_\_\_\_\_  
DATE