



## PATIENT INFORMATION

Patient's Name: _____	Soc. Sec. #: _____	Date: _____
Nickname: _____	Birthdate: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address: _____	City: _____	Zip: _____
Home Phone: _____	Business Phone: _____	
Cell Phone: _____	Email: _____	
Responsible Party: _____	Relationship to Patient: _____	
School (if applicable): _____	Occupation (if applicable): _____	
General Dentist: _____	Physician: _____	
Referred by: _____	Ages of Children at Home: _____	

## RESPONSIBLE PARTY INFORMATION

<b>IF PATIENT IS AN ADULT:</b>	
Employer: _____	Spouse's Name: _____
Position: _____	Employer: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Business Number: _____	Business Number: _____
Social Security #: _____	Social Security #: _____
<b>IF PATIENT IS A CHILD:</b>	
Father's Name: _____	Mother's Name: _____
Employer: _____	Employer: _____
Position: _____	Position: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Business Number: _____	Business Number: _____
Email: _____	Email: _____
Social Security #: _____	Social Security #: _____

## DENTAL INSURANCE INFORMATION

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Policy Holder: _____	Policy Holder: _____
Birthdate: _____ Soc. Sec. #: _____	Birthdate: _____ Soc. Sec. #: _____
Employer: _____	Employer: _____
Insurance Carrier: _____	Insurance Carrier: _____
Insurance Phone #: _____	Insurance Phone #: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Policy #: _____	Policy #: _____