

**PATIENT INFORMATION**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE  
LAST FIRST MADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIPBIRTHDATE: \_\_\_\_\_ TELEPHONE:  \_\_\_\_\_  \_\_\_\_\_  
MO. DAY YR. HOME OFFICE

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PLACE OF EMPLOYMENT (OR SCHOOL): \_\_\_\_\_ GRADE \_\_\_\_\_ S.S.# \_\_\_\_\_

DENTAL INSURANCE CO.: \_\_\_\_\_ GROUP NO. \_\_\_\_\_

Has any member of your family ever been treated in our office?:  YES  NO

Whom may we thank for referring you to our office? \_\_\_\_\_

**FAMILY INFORMATION****FATHER / HUSBAND / GUARDIAN****MOTHER / WIFE / GUARDIAN**

Name:

LAST FIRST M

LAST FIRST M

Address:

STREET CITY STATE ZIP

STREET CITY STATE ZIP

Telephone:

HOME # WORK #

HOME # WORK #

Birthdate/SS#:

MO. DAY YR. SS #

MO. DAY YR. SS #

Employer:

EMPLOYER

EMPLOYER

Dental

Insurance Co.:

DENTAL INSURANCE GROUP #

DENTAL INSURANCE GROUP #

Group #:

**PERSON RESPONSIBLE FOR ACCOUNT** \_\_\_\_\_**PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY**NAME \_\_\_\_\_ TEL # \_\_\_\_\_  
LAST FIRST MADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP**METHOD OF PAYMENT****A charge will be made for all broken appointments.****Payment is expected when services are rendered.****SIGNATURE OF RESPONSIBLE PARTY**

x \_\_\_\_\_ DATE \_\_\_\_\_

 Adult Patient  Father (or Husband)  Mother (or Wife)  Guardian

