PATIENT INFORMATION

REASON FOR VISIT:

E-MAIL ADDRESS:	**NICKNAME:**
CELL PHONE: ( )	**HOME PHONE: ( )**
LAST NAME:	**WORK PHONE: ( )**
1ST NAME & INITIAL:	**EMPLOYER:**
SEX: BIRTHDATE:	**MEDICAL ALERTS:**

PATIENT S.S.N. #	**STUDENT STATUS: ☐ FULL TIME ☐ PART TIME SCHOOL: CITY:**

CHECK APPROPRIATE BOX: ☐ MINOR ☐SINGLE ☐MARRIED ☐ DIVORCED ☐ WIDOWED ☐SEPARATED

BILLING INFORMATION

RESPONSIBLE PARTY'S NAME:	**S.S.N. #**
BIRTHDATE FOR RESPONSIBLE PARTY:	**DRIVER'S LICENSE #:**

PATIENT'S ADDRESS: APT. #

CITY: STATE: ZIP CODE:

DENTAL INSURANCE INFORMATION (primary)

NAME OF: POLICY HOLDER:	**BIRTHDATE OF POLICY HOLDER:**	**RELATION TO PATIENT:**
S.S.N. # OF POLICY HOLDER'S:	**POLICY HOLDER'S EMPLOYER:**	
NAME OF INSURANCE COMPANY:	**EMPLOYER'S PHONE NUMBER:**	

ADDRESS OF INSURANCE COMPANY:

CITY: STATE: ZIP CODE: PHONE #

GROUP NUMBER:	**EFFECTIVE DATE OF COVERAGE:**
YEARLY COVERAGE AMOUNT:	**DEDUCTIBLE:**

DENTAL INSURANCE INFORMATION (secondary)

NAME OF POLICY HOLDER:	**BIRTHDATE OF POLICY HOLDER:**	**RELATION TO PATIENT:**
S.S.N. # OF POLICY HOLDER'S:	**POLICY HOLDER'S EMPLOYER:**	
NAME OF INSURANCE COMPANY:	**EMPLOYER'S PHONE NUMBER:**	

ADDRESS OF INSURANCE COMPANY:

CITY: STATE: ZIP CODE: PHONE #

GROUP NUMBER:	**EFFECTIVE DATE OF COVERAGE:**
YEARLY COVERAGE AMOUNT:	**DEDUCTIBLE:**