

**PATIENT INFORMATION**

Patient's Full Name: \_\_\_\_\_ Name you go by: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: Single / Married / Divorced / Widowed  
Place Of Employment Or School & Grade: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Person To Contact In Case Of Emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Contacts Address: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_  
Whom We May Thank For Referring You: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Full Name: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: Single / Married / Divorced / Widowed  
Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Employer's Address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Name Of Spouse Or Other Parent: \_\_\_\_\_ Address: \_\_\_\_\_  
Spouse's Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**INSURANCE INFORMATION**

Do You Have Dental Insurance? Yes or No  
Primary Insurance Company Name & Address \_\_\_\_\_  
\_\_\_\_\_  
Primary Insurance Company Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Insured's Full Name: \_\_\_\_\_ Insured's Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Group #: \_\_\_\_\_ Insurance I.D. #: \_\_\_\_\_  
(Example: Social Security #)

**SECONDARY INSURANCE INFORMATION**

Other family member employed? Yes or No  
Spouse's Full Name: \_\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Spouse's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Group #: \_\_\_\_\_  
Spouse's Employer Name & Address: \_\_\_\_\_  
Secondary Insurance Company Name & Address: \_\_\_\_\_  
\_\_\_\_\_  
Secondary Insurance Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

I authorize the dentists or health care professionals to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation administering claims for insurance benefits. I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor. I hereby understand that my insurance will be filed as a courtesy to me, and I will be responsible for any remaining balance not covered by my insurance company.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_