Patient's Name_____ Age_____ Date of Birth_____

SSN# _____ Driver License# _____ E-mail _____

Address _____Preferred Name_____

City _____State _____ Zip _____

Cell Phone: _____Work Phone: _____

Email Address: _____

Marital Status: **SINGLE MARRIED WIDOWED DIVORCED** FEMALE ☐ MALE ☐

Emergency Contact_____ Relation_____ Phone _____

Employment Status: **FULL TIME PART TIME RETIRED UNEMPLOYED** STUDENT STATUS: **FULL TIME PART TIME N/A**

Person Responsible for the Account _____ Relation _____

Employer/ Co Name _____ Group # _____

Insurance Company_____ Phone #_____

Insurance Company Address, City, State, Zip_____

Subscriber's Name _____ Relationship to Patient_____

Subscriber ID #_____ Subscriber's Date of Birth_____

Sec Ins Company_____ Phone #_____

Subscriber's Name _____ Relationship to Patient_____

Subscriber ID #_____ Subscriber's Date of Birth_____

Previous Dentist: _____

Who Can We Thank for Referring You: _____

_____ _____

Signature of Patient or Guardian **Date**