

PATIENT INFORMATION

Date _____

Legal Name: First: _____ M.I. _____ Last: _____

Prefers to go by: _____ **Patient's SS #** _____

Birth Date _____ **Name & Relationship of Guardian** _____

Home Address: _____

Street

City

State

Zip

Home phone: (____) _____ **Work:** (____) _____

Cell: (____) _____ **Email address:** _____

Driver's License # _____

How would you prefer we **contact** you? Email _____ Cell _____ Home _____ Work _____

Patient's or Guardian's **Employer:** _____ **Occupation:** _____

Work Address: _____ Yrs. Employed: _____

Spouse's First Name: _____ M.I.: _____ Last: _____

Spouse's Employer: _____ Occupation: _____

Spouse's SS#: _____ Birth Date: _____ Cell: (____) _____

Whom may we thank for referring you to our office? _____

Have any other family members been to this office? **Y or N** If so, whom? _____

INSURANCE INFORMATION

Insured's Name _____ Group Number: _____

Insured ID: _____ Insured SS #: _____

Insured's Date of Birth _____ Do you have dual coverage? Yes _____ No _____

EMERGENCY INFORMATION

Emergency Contact Person: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Relationship to Patient: _____

Address: _____

Street

City

State

ZIP

I understand I am **responsible for my account**. If I have dental insurance the claims will be filed for me, and I will be responsible for any remaining balance. I also understand this office values my time and will make every effort to honor my appointment times. Likewise, if I fail to keep my appointments without **24 hours' notice**, I understand I will be billed the cancellation fee, or possibly be dismissed from the practice if this policy is violated repeatedly. If you are the parent or guardian of a minor child and are bringing them for treatment in this office, you are responsible for the child's balance.

Signature _____ Relationship to Patient: _____