



First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Patient is:  Policy Holder  Responsible Party

**Patient Information:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Work: \_\_\_\_\_ ext \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security: \_\_\_\_\_ Sex:  Male  Female

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Employer's Address Line 2: City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DL #: \_\_\_\_\_ Email: \_\_\_\_\_  Check to receive emailed appt reminders

Preferred Pharmacy: \_\_\_\_\_ Location/Phone #: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency Contact's Name: \_\_\_\_\_ Emergency Contact #: \_\_\_\_\_

**Responsible Party** (if not patient) First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Work: \_\_\_\_\_ ext \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Employer's Address Line 2: City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

**Insurance:**

Policy Holder's Name: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child

Employer: \_\_\_\_\_ Employment Status:  Full Time  Part Time  Retired

Name of Insurance Co: \_\_\_\_\_ Insurance Co Phone #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

