TODAY'S DATE: ______________

Who referred you to this office? ________________________ Social Security # ____________________

Patient's Name ____ Birthdate _________________

Address ____ City _____________ ST____ ZIP ____________

Home Phone ______________________ Work Phone ______________________ Ext ____________

Cell Phone ____________________ Pager__________________ E-Mail________________________

Employer ________________________________ City _____________ Occupation _________________

Name of Spouse / Parent / Guardian ______________________________ Birthdate_______________
(circle one)
Social Security # ____________________

Address if different ____________________________ City___________ ST_____ ZIP ____________

Home Phone ________________________ Work Phone _________________ Ext___________

Employer __________________________________City ______________ Occupation __________________

In case of emergency, whom shall we notify other than spouse?

Name________________________ Relationship_____________ Phone ____________________________

INSURANCE INFORMATION

EMPLOYEE NAME ____________________________

INS CO NAME________________________________

INS CO ADDRESS ____________________________

INS CO CITY, ST, ZIP__________________________

INSURANCE PHONE __________________________

GROUP / POLICY # ___________________________

EMPLOYEE SS # _____________________________

BIRTHDATE ________________________________

INSURANCE INFORMATION

EMPLOYEE NAME ____________________________

INS CO NAME________________________________

INS CO ADDRESS ____________________________

INS CO CITY, ST ZIP __________________________

INSURANCE PHONE __________________________

GROUP / POLICY # ___________________________

EMPLOYEE SS # _____________________________

BIRTHDATE ________________________________

Patient Acknowledgments:

- I understand that I am responsible for any uninsured balance.
- If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.

I have read the above: Signature ____ Date ____________________

PATIENT INFORMATION PART 1