Patient Information

First Name________________________________M.I.__________Last Name__________________________

DOB____/____/______SS#______-_____-________ □M □F □Other DL#_____-_____________

E-mail ____ Address _____________________________________

Apt._______City_______________State_________ZIP___________ Home# ( ) ______-____________

Cell# ( ) ______-_______________Work# ( ) ______-___________________

Referred by____

In case of emergency please contact_____________________________ Relationship: _________________

Phone# ( ) _____-______________ Marital Status: □Married □Single □Divorced □Domestic Partner

Dental Insurance Information

Policy Holder: □ Self □Spouse □Parent □Domestic Partner

Policy Holder Name _____________________________________ DOB ______/______/_______

Phone# ( )______-__________ Address ____

City __________________ State _____ ZIP ___________ Employer _________________________________

Ins Company ____________________________ Policy/ID# ___________________________________

Group# _______________________ Customer Service# ( ) _______-______________

Do you have Secondary Dental Insurance? □ Yes □ No

Secondary Dental Insurance Information

Policy Holder: □ Self □Spouse □Parent □Domestic Partner

Policy Holder Name _____________________________________ DOB ______/______/_______

Phone# ( )______-__________ Address ______________________________ SS#_______-_____-______

City __________________ State _____ ZIP ___________ Employer _________________________________

Ins Company ____________________________ Policy/ID# ___________________________________

Group# _______________________ Customer Service# ( ) _______-______________

Medical Insurance Information

Medical Doctor (First & Last Name) ____________________________Contact# (   )______-__________

Policy Holder: □ Self □Spouse □Parent □Domestic Partner

Policy Holder Name ____________________________________ DOB ______/______/_______

Phone# (   )______-__________ Address ____________________________ SS#_________-_____-_____

City __________________ State _____ ZIP ___________ Employer _______________________________

Ins Company ____________________________ Policy/ID# ___________________________________

Group# ______________________ Customer Service# (   ) ______-______________

Initial Appointment Information

Reason for today's visit ____

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Are you in pain? □ Yes □ No If yes, for how long? Describe symptoms:

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