Patient Information

First Name_______________________________M.I.__________Last Name_________________________

Preferred Name _________________________________ DOB______/______/_____________

SS#______-_____-________ □M □F □Other Preferred Pronoun: □ He/him □ She/her □ They/them

DL# _____-________________E-mail ___________________________________

Address ____

Address __________________________________ City_________State________ZIP__________

Home# (   ) _____-_______Cell# (   ) _____-______________Work# (   ) _____-_______

In case of emergency please contact: ____

Relationship: ______________________________ Phone# (   ) _______-________________________

Marital Status: □Married □Single □Divorced □Domestic Partner

Referred by: ____

Dental Insurance Information

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

Policy Holder Name ____________________________________ DOB ______/______/_______

SS#______-_____-________ 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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