

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 _____
Parent or Guardian if a minor

PATIENT INFORMATION PART 1