Patient Number: _____ **Chart Number:**_____

Patient Information

Patient Name: LAST: _____FIRST:_____M.I. ___ Nickname _____ School:_____

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Social Security Number: _____

Mothers Name_____ Number: (___) _____Fathers Name_____ Number: (___) _____

Legal Guardians Name_____ Number:(___)_____

Minor Patients Primary Residence_____

Check all family members living with minor patient: Both Parents__Mother__ Father__Step parent__ Legal guardian__ Foster__

Responsible Party Information (Mother, Father, Legal Guardian)

Name: LAST: _____ FIRST:_____ M.I.: _____ Relationship: _____

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Social Security Number: _____

Address: Street: _____ Apartment #: ___

City: _____ State: _____ Zip Code: _____

Employer:_____ Number of years at employer:___ Occupation:_____

Employer Address:_____

Home Phone No.: (_____) _____ Message Phone No.: (_____) _____ Cell: (_____) _____

Work No.: (_____) _____E-mail:_____

Emergency contact: Name_____Relationship to patient_____ Phone No: (_____) _____

Who may we thank for referring you to our office: ☐ Passing By ☐ Mailer ☐ Grocery Store Advertisement

☐ Patient: _____ ☐ Doctor: _____ ☐ Other: _____

Please List All Members Of Your Immediate Family

Family Member's Full Name	Now A Patient In This Office?		Date of Birth	Relationship to Patient
1.	☐ Yes	☐ No		
2.	☐ Yes	☐ No		
3.	☐ Yes	☐ No		
4.	☐ Yes	☐ No		
5.	☐ Yes	☐ No		
6.	☐ Yes	☐ No		

Primary Dental Insurance Information

Insured's Name: _____

Insured's Date of Birth: ____/____/____

Insured's Social Security Number: _____

Insured's Employer:_____

Insured's Employer Phone No.: (_____) _____

Insurance Company Name: _____

Insurance Company Phone No: (_____) _____

Insurance Group No.: _____ Local: _____

Secondary Dental Insurance Information

Insured's Name: _____

Insured's Date of Birth: ____/____/____

Insured's Social Security Number: _____

Insured's Employer: _____

Insured's Employer Phone No.: (_____) _____

Insurance Company Name: _____

Insurance Company Phone No: (_____) _____

Insurance Group No.: _____ Local: _____

Please indicate which of the above telephone numbers is preferred for use, to contact you regarding appointments, treatment, and your account (___) _____ Signature_____Date _____

The foregoing information and the dental/medical histories are true and correct. I hereby authorize the Dental Office to release my dental/medical information and all information about my dental treatment to third party payors and other health professionals. I hereby assign, transfer and direct payment directly to the Dental Office of my insurance benefits/coverage, if any, for all treatment performed; however, I accept responsibility and will pay all charges not paid by insurance for any reason.

Signature: _____ Driver's Lic #: _____ State: _____ Date: ____/____/____
(If Minor, Parent or Guardian)