

**Patient Information**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  Male  Female  
Last First Middle

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ 18 yrs/older – School Attending \_\_\_\_\_

If a patient is a minor give parent or guardian name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_ Dentist \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  Single  Married  Divorced  Separated

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ e-mail \_\_\_\_\_

Relationship to Patient:  Mother  Father  Stepmother  Stepfather  Legal Guardian  Other \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Last First Middle

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient:  Mother  Father  Stepmother  Stepfather  Legal Guardian  Other \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

**Insurance Information**

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_  
Street City State Zip

Relationship to Patient:  Mother  Father  Stepmother  Stepfather  Legal Guardian  Other \_\_\_\_\_

Do you have double coverage?  Yes  No

If Yes, Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_  
Street City State Zip

Relationship to Patient:  Mother  Father  Stepmother  Stepfather  Legal Guardian  Other \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

**I understand I am financially responsible for all charges regardless of insurance coverage and I also understand that where appropriate, credit bureau reports may be obtained. A FINANCE CHARGE OF 1.5% MONTHLY/18% ANNUALLY WILL BE APPLIED TO ANY BALANCE OVER 60 DAYS.**

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_