PLEASE TELL US ABOUT YOURSELF ☺

Today's Date: _____ E-mail Address: _____

NAME: FIRST_____INITIAL____LAST_____

I prefer to be called: _____ ☐ Male ☐ Female

Date of Birth: _____ SS# _____

Age: _____ Driver's License # _____

HOME Street Address _____

HOME City State Zip _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

HOME # (_____) _____ CELL # (_____) _____

WORK # (_____) _____ Ext: _____

EMPLOYER NAME

_____

Employer's Street Address _____

Employer's City State Zip _____

How long there? _____ Occupation: _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

SPOUSE INFORMATION

His / Her FULL NAME: _____

Employer:_____

Work Phone #: (_____) _____ Ext: _____

Cell/Other #: (_____) _____

Date of Birth: _____ SS# _____

Driver's License # _____

PERSON RESPONSIBLE FOR ACCOUNT

(IF OTHER THAN YOURSELF)

His / Her FULL NAME: _____

Billing address: _____

_____

Employer: _____

Work Phone #: (_____) _____ Ext: _____

Cell/Other #: (_____) _____

Date of Birth: _____ SS# _____

Driver's License # _____

INSURANCE COVERAGE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Subscriber's Full Name: _____

Subscriber's Date of Birth: _____

Subscriber's SS#: _____

Subscriber's relationship to the patient: _____

Subscriber's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Subscriber's Full Name: _____

Subscriber's Date of Birth: _____

Subscriber's SS#: _____

Subscriber's relationship to the patient: _____

Subscriber's Employer: _____

EMERGENCY INFORMATION

EMERGENCY CONTACT NAME: _____

Relationship: _____

Work Phone #: (_____) _____ Ext: _____

Cell/Other #: (_____) _____

PERSONAL PHYSICIAN NAME: _____

Physician Phone #: (_____) _____