Date:________________________ Date of Birth:_______/_______/_______

Mr. / Mrs. / Ms. / Dr. *(Please Circle)* **Social Security#_____/_____/_____**

Last Name:____________________ First Name____________________ Middle Initial __________

Address:________________________________City:______________State:_______Zip___________

- Married
- Single
- Child
- Dependent

If Child or Dependent, name and address of responsible party:
____
____
____

Home Phone# ( ) _________________________ Business Phone# ( ) _______________________

Cell Phone# ( ) __________________________ Fax # ( )________________________________

Present Employer:________________________________Occupation:_____________________________

Position:__________________________________ Employer Phone# ( )________________________

Spouses Name: ______________________________ Spouses Employer:__________________________

Spouses Present Position:______________________ Spouses Business Phone# ( )_________________

Someone to contact in case of emergency: ____

Their Home Phone# ( ) _____________________ Their Business Phone# ( )_____________________

Person responsible for account:___________________________ Relationship:_______________________

***Who is your general dentist?*___________________*Who is your medical doctor?*___________________**

Why have you been referred to our office? ____

Dental Insurance? ___Yes ___No Insurance Co. Name: __________________________________

Insurance company address:_______________________________ Phone# ( ) ______________________

Group # : __________________ Employer :____

Insured Name: _______________________________ Social Security # : _______/________/________

Date of Birth (insured) _______/_______/_______ Relationship:__________________

PATIENT HISTORY