Patient Information

Mr./Ms./Mrs./Dr. First Name:______________________Last Name: ___________________________ MI: __________
Home Phone(____)_______________Cell Phone (____) _________________ Work Phone _)_____________________
Email Address: ____
Home Address: _______________________________ City: ________________________ State: _______ Zip: _______
Date of Birth: M/DD/YYYY _____/_____/_____ Gender: M F Social Security Number(SSN): ____________________
Spouse or Parent/Guardian (if minor) Name: ____
Emergency Contact: _____________________________ Relationship: ______________Phone:____________________
Referred By: ____

Employer Information

Employer: ____ Phone: (____)___________________
Address: _________________________________ City: ______________________ State:________ Zip: ____________

Dental Insurance Information

Patient's Relationship to Primary Insured: Self Spouse Child Other
Name of Insured (First, I, Last): ________________________________ Insured DOB (MM/DD______________
Insc Co: ____ Insc ID: ___________________________________
Group : ______________________________ Plan Name: ____
Business Address: _______________________________________ City: ______________________State: _________
Phone: (____) _____________________ Fax: (____)___________________
Email:_____________________________________

Please present your insurance card so that we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? Yes No IF **YES**, PLEASE COMPLETE THIS SECTION.
Patient's Relationship to Primary Insured: Self Spouse Child Other__________________________________
Name of Insured (First, MI, Last): ______________________________ Insured DOB (MM/DD/YYYY): _______________
Insc Co: ____ Insc ID: ____________________________________
Group : ______________________________ Plan Name: ____
Business Address: ___________________________________ City: _____________________ State:
________Zip:______________
Phone: (____) _____________________ Fax: (____)______________________

Medical Contacts

Primary Care Physician: _____________________________________ Phone: (____) __________________________

I certify this information is true, accurate, and complete to the best of my knowledge.

INITIAL ___________DATE: ______________________