Patient Information **Date: _____**

Name _____ Preferred Name: _____

Address _____ City, State _____

&Zip _____

****Please circle phone number that can be used for appointment confirmation****

Home Phone _____ Work Phone _____

Cell or Message Phone _____

Date of Birth _____

Email _____

Marital Status (please check box): Single [ ], Married [ ], Widowed [ ], Divorced [ ], other [ ]

Current Dental Status

Are you currently having any dental problems? No [ ], Yes [ ]

If 'Yes', please explain

_____

Responsible Party Information

Name of Responsible Party (guardian) _____

Social Security # _____
(For billing purposes … not necessary if paying in full at time of service)

Address (if different than patient) _____

Employer _____ Occupation _____

Employer / Work Phone _____

How would you like to pay for your portion of the provided services? Cash [ ], Check [ ], Credit Card [ ], Other [ ]

Responsible Party's Spouse

Name of Responsible Party (guardian) _____

Social Security # _____
(For billing purposes … not necessary if paying in full at time of service)

Address (if different than patient) _____

Employer _____ Occupation _____

Employer / Work Phone _____

Dental Insurance

Insurance Company _____

Insured Name _____

Insured DOB _____

Subscriber Number _____

Group # _____

Employer _____

Insurance Co. Address _____

Insurance Co. Phone # _____