Today's Date________________________

Patient Information (Confidential)

Name____
First Middle Last

Address____
Street P.O. Box

____
City State Zip Code

Home Phone_____________Work Phone______________Cell Phone_________________________

Preferred contact number:__________________________

Date of Birth__________________Social Security#_____________________

Employer________________________Employer's Phone #________________

Preferred Pharmacy:______________________________Pharmacy Phone number:_______________

Person to notify in case of an emergency:____
Name Phone #

Responsible Party Information (***complete if patient is not the responsible party or if patient is a minor***)

Name____
First Middle Last

Address____
Street P.O. Box

____
City State Zip Code

Home Phone_________________Work Phone_________________Cell Phone___________________

PRIMARY DENTAL INSURANCE INFORMATION	**SECONDARY DENTAL INSURANCE INFORMATION**
Name of insured:	Name of insured:
Relationship to patient:	Relationship to patient:
Employer or Group:	Employer or Group:
Social Sec# or ID#:	Social Sec#or ID#:
Date of Birth:	Date of Birth:
Insurance company:	Insurance company:
Insurance company address:	Insurance company address:
Insurance company phone number:	Insurance company phone number:

Updated 1/30/17