

## PATIENT INFORMATION (CONFIDENTIAL)

<b>PATIENT'S NAME</b> _____			
FIRST	MI	LAST	PREFERRED NAME
ADDRESS _____	CITY _____	STATE _____	ZIP _____
HOME PHONE _____	WORK PHONE _____	CELL PHONE _____	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MINOR <input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED
BIRTHDATE _____	SSN _____		
EMPLOYER _____			
EMPLOYER ADDRESS _____	CITY _____	STATE _____	ZIP _____
IF A COLLEGE STUDENT, <input type="checkbox"/> F.T. <input type="checkbox"/> P.T., NAME OF SCHOOL _____	EST GRAD DATE _____		
IF A MINOR, PARENT'S / GUARDIAN'S NAME _____			
WHOM MAY WE THANK FOR REFERRING YOU? _____			
PERSON TO CONTACT IN CASE OF EMERGENCY _____	PHONE _____		
WHEN WAS THE LAST TIME YOU HAD DENTAL X-RAYS TAKEN? _____			

<b>RESPONSIBLE PARTY</b>	<input type="checkbox"/> SAME AS PATIENT
NAME OF PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT _____	RELATIONSHIP TO PATIENT _____
BIRTHDATE _____	E-MAIL (if preferred method of contact) _____
SSN _____	CELL PHONE _____
ADDRESS _____	CITY _____
EMPLOYER _____	HOME PHONE _____
	STATE _____
	ZIP _____
	WORK PHONE _____

<b>INSURANCE INFORMATION</b>	
INSURANCE COMPANY _____	
<input type="checkbox"/> SAME AS PATIENT <input type="checkbox"/> SAME AS RESPONSIBLE PARTY	
NAME OF POLICY HOLDER _____	RELATIONSHIP TO PATIENT _____
BIRTHDATE _____	SSN _____
EMPLOYER _____	WORK PHONE _____
DO YOU HAVE ADDITIONAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURANCE COMPANY _____	
NAME OF POLICY HOLDER _____	RELATIONSHIP TO PATIENT _____
BIRTHDATE _____	SSN _____
EMPLOYER _____	WORK PHONE _____

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_