Patient Information

Today's Date:

PATIENT INFORMATION

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F

Home Phone_____ Wireless Phone_____ Work Phone _____

Email_____

Name of referring DR.? _____

PATIENT ADDRESS

Address_____ City_____ State_____Zip_____

Policy Holder Address if different from patient:

Address_____ City_____ State_____Zip_____

MOTHER'S INFORMATION

Name_____ Guardian [ ] Y [ ] N Step Mother [ ] Y [ ] N

Birthdate_____ SS#_____ DL#_____ Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Employer_____

Email_____

FATHER'S INFORMATION

Name_____ Guardian [ ] Y [ ] N Step Father [ ] Y [ ] N

Birthdate_____ SS#_____ DL#_____ Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Employer_____

Email_____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____ Relation _____ Employer_____

Address_____ City_____ State_____Zip_____

DL#_____SS#_____Work Phone_____Wireless Phone _____

Emergency Contact _____Emergency Phone _____

PRIMARY INSURANCE POLICY

Patient relationship to policy holder: [ ] Self [ ] Dependent [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

SECONDARY INSURANCE POLICY

Your relationship to policy holder: [ ] Self [ ] Dependent [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.
The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been made.

Signature_____Date_____