Confidential Patient Information

Date:_____ Please Print Clearly

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ M/F_____

If patient is a minor, give parent's or guardian's name _____

Who referred you to our office? _____ Your General Dentist is? _____

Confidential Responsible Party Information

Name _____ Marital Status M D S W Sep
Last First Middle

Social Security # _____ Birthdate _____ Relationship to Patient _____

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Do you rent or own? _____ How long at this address? _____ Home Phone _____

Work Ph _____ Ext ____Cell Ph _____Email Address _____

Would you like to receive text message appointment reminders? Yes _____ No _____

Previous Address (if less than 3 years) _____
Street City State Zip

Employer _____ Occupation _____ No. Years Employed_____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Social Security # _____ Birthdate _____

Address _____
Street City State Zip

Employer _____ Occupation _____ No. Years Employed_____

Cell Phone: _____ Work Phone _____ Ext. ____

Orthodontic Insurance Information

Policy Holder's Name _____ and Social Security # _____

Do you have secondary insurance? No _____ Yes _____

Policy Holder's Name _____ and Social Security # _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that there will be a credit bureau report obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

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