Date_____ # Confidential Responsible Party Information   A B C

Name_____ Marital Status_____

Home Address_____ Own_____ Rent_____

Mailing Address (if different)_____

How long at this address?_____ Email Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ Yrs Employed_____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ Yrs Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Confidential Patient Information

Patient's Name_____

Home Address_____

Home Phone_____ Birthdate_____ Email Address_____

If patient is a minor, give parent's or guardian's name_____ __

Other family members seen by us?_____

Whom may we thank for referring you to our office?_____

Dental Insurance Information

Primary

Policyholder's Name_____ Social Security #_____ Birthdate_____

Policyholder's Address(if different than above)_____

Ins Co_____ Group#_____ ID#_____

Ins Co Address_____ Ins Co Phone #_____

Policyholder's Employer_____ Work Phone#_____

Secondary

Policyholder's Name_____ Social Security #_____ Birthdate_____

Policyholder's Address(if different than above)_____

Ins Co_____ Group#_____ ID#_____

Ins Co Address_____ Ins Co Phone #_____

Policyholder's Employer_____ Work Phone#_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone Number_____ Relationship_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____