Personal Information

Patient
Name Mr/Mrs/Miss/Ms ____ SSN ________________

Address ____ Driver's License No. ________________

City ____ State __________ Zip ____________

Place of Employment ____________________________________ Occupation ________________

Home Phone ________________ Work Phone ________________ Cell Phone ________________

Date of Birth ________________ Email Address ____________________________________

Name of Family Member Already a Patient Here ____________________________________

Referred By: ☐ Insurance Co. ☐ Internet - site__________ ☐ Friend - name____________ ☐ Other________

Responsible Party Information

Who is financially responsible for payment? Self ________ Other ____________________________

If other, please provide name (Last-First-Middle) ____________________________________

Address (Street-City-State-Zip) ____

Work Phone ____________________________ Home Phone ____________________________

Name of Employer ____

I will be paying today by: ☐ Check ☐ Cash ☐ Visa/MC ☐ Care Credit (prior approval required)

Dental Insurance Information

Dental Ins. Co. Name ____ SSN ________________

Name of Subscriber/Holder ______________________________ Phone ____________________

Place of Employment ______________________________ Member No. ____________________

Date of Birth ____________________

***Please list PRIMARY INSURANCE only. We do not file secondary insurances. If you are unsure, please ask the receptionist.**

Dependent Information

Dependent's Name ____ ☐ M ☐ F Date of Birth __________

Dependent's Name ____ ☐ M ☐ F Date of Birth __________

Dependent's Name ____ ☐ M ☐ F Date of Birth __________