Patient Information

First Name: _____ Last Name: _____Middle Initial: _____

Preferred Name: _____ Title (Circle One):◯Miss◯Mrs.◯Ms.◯Mr.◯Dr.◯Rev.◯Prof.

Birth Date: _____ Age: _____ Social Security: _____

Sex: M F Trans Prefer not to respond

Marital Status: _____ Spouse's name: _____

Address: _____

City: _____ State/Zip: _____

Home Phone: _____Work Phone: _____ext.: _____

Cell Phone: _____ Email address: _____

Circle how you would like to be contacted for your appointments: Home Cell Work Email Text

Employment Status: Full-Time Part-Time Retired Student Unemployed

Job Title: _____ Place of Work: _____

How did you hear about us? _____

Emergency contact information

Name: _____ Phone Number: _____

Relationship to patient: _____

Previous Dentist

Responsible Party (if someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Birth Date: _____ Age: _____ Social Security: _____

Address: _____

City: _____ State/Zip: _____

Primary Insurance Information

Name of Policyholder: _____

Relationship to patient: _____

Birth Date: _____ Social Security or Member ID#: _____

Insurance company name: _____ Telephone number: _____

Company Address: _____ City/State/Zip: _____

Group number: _____ Employer: _____