PATIENT INFORMATION **TODAY'S DATE**_____

PATIENT NAME_____ **DATE OF BIRTH**_____

HOME ADDRESS _____ **APT. #**_____

CITY _____ **STATE** _____ **ZIP CODE**_____

TELEPHONE: **HOME #** _____ **SSN #** _____

WORK # _____ **EMPLOYER** _____

CELL # _____

FULL-TIME COLLEGE STUDENT ? **YES** _____ **NO** _____ **NAME OF SCHOOL** _____

SPOUSE'S NAME _____ **SPOUSE'S SSN #** _____

SPOUSE'S EMPLOYER _____

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

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT: **Same person as patient above ?** **YES** _____ **NO** _____

NAME OF RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT** _____

HOME ADDRESS _____ **APT.#** _____

CiTY _____ **STATE** _____ **ZIP CODE**_____

TELEPHONE: **HOME #** _____ **SSN #** _____

WORK # _____ **EMPLOYER** _____

CELL # _____

IS THERE DENTAL INSURANCE COVERAGE ? **YES** _____ **NO** _____ ***IF YES, PLEASE COMPLETE NEXT SECTION.***

PRIMARY INSURANCE COVERAGE:

POLICY HOLDER'S NAME _____ **ID # OR SSN#** _____

POLICY HOLDER'S DATE OF BIRTH _____ **RELATIONSHIP TO PATIENT Self** ____ **Spouse** ____ **Child** _____

INSURANCE COMPANY NAME _____ **GROUP #** _____

CLAIMS ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CUSTOMER SERVICE TELEHPONE # _____

IS PATIENT COVERED BY MORE THAN ONE DENTAL INSURANCE ? _____ **IF YES, PLEASE COMPLETE NEXT SECTION.**

SECONDARY INSURANCE COVERAGE:

POLICY HOLDER'S NAME _____ **ID # OR SSN#** _____

POLICY HOLDER'S DATE OF BIRTH _____ **RELATIONSHIP TO PATIENT Self** ____ **Spouse** ____ **Child** _____

INSURANCE COMPANY NAME _____ **GROUP #** _____

CLAIMS ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CUSTOMER SERVICE TELEHPONE # _____