

**PATIENT INFORMATION**

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ May we call you at work? \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Marital Status \_\_\_\_\_ S.S.# \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

**CHILD INFORMATION**

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ S.S.# \_\_\_\_\_

**PARENT INFORMATION**

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ May we call you at work? \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Marital Status \_\_\_\_\_ S.S.# \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

**SPOUSE**

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ S.S.# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_

**RESPONSIBLE PARTY**

Who is responsible for payment on this account? \_\_\_ Myself \_\_\_ My Spouse \_\_\_ Other (please complete the following information)  
Full Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Complete Address \_\_\_\_\_ Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_

**DENTAL INSURANCE**

Primary Insurance Information:

Insured's Name \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Information:

Insured's Name \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ Group # \_\_\_\_\_

In case of emergency who should we notify? \_\_\_\_\_ Phone \_\_\_\_\_  
Whom can we thank for referring you to our office? \_\_\_\_\_

I understand that I am responsible for the payment of dental services provided, regardless of insurance benefits, and that these payments are due at the time services are rendered unless financial arrangements have been made prior to my visit. All overdue accounts are subject to a 1.5% finance charge per month.

Signed: \_\_\_\_\_ Date \_\_\_\_\_