PATIENT INFORMATION

First Name:________________________________ Last Name:_______________________________________ MI:______

Preferred Name:______________________________ Who is responsible for your account:__________________________

Street Address: ____ City:___________________ State: _____ Zip: ________

Home Phone: ______________________ Work Phone:_______________________ Cell Phone: _____________________

Circle: Male / Female Circle Marital Status: Single / Married / Separated / Divorced / Widowed

Birthdate: ________/________/________ Social Security #: _______-_______-_______

Email Address: _______________________________________@________________________________.__________

Other than # listed above

Emergency Contact: _______________________________ Relationship:__________________ Phone: ______________

RESPONSIBLE PARTY – the person financially responsible for your account

First Name: __________________________________ Last Name: ____________________________________ MI: ______

Employer:____ Relationship to Patient: ___________________

Street Address: ______________________________________ City: ___________________ State: _____ Zip: __________

Home Phone: __________________________ Work Phone: _____________________ Cell Phone: __________________

Circle Gender: Male / Female Birthdate: ______/______/______ Social Security #: ______-_____-_____

PRIMARY DENTAL INSURANCE

Full Name of Policy Holder: ___________________________________

Relationship to Patient: ______________________________________

Address: ____

____

Home # ______________ Work #_________________ Cell #_______________

Policy Owner's Birthdate:_______________________________________

Policy Owner's Social Security # __________________________________

Policy Owner's Occupation:_____________________________________

Policy Owner's Employer:_______________________________________

Insurance Company:__________________________ Group #:____________

FOR CHILD PATIENTS

Mother's Name: ____________Phone:_________
Employer: ______________________________
Email Address:____________________________

Father's Name: ____________Phone:__________
Employer: ______________________________
Email Address:____________________________

REFERRAL INFORMATION circle one

Who may we thank for referring you to our practice?

Existing Patient-----Dental Office----- Post Card
Billboard-----Yellow Pages-----Health Fair -----
Radio-----Newspaper-----Other_____________
Name of person or office referring you to our practice:________________________________

In order to stay connected with you, we use a convenient communication system that includes Post Cards, Emails, Texts & Personal Courtesy Calls. To best serve you, WHO would you prefer we communicate with?
Name______________________________ **E-Mail**______________________________________ **Cell #**______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print name)____________________________, have received a copy of this office's Notice of Privacy Practices.

Signature: ____ Date: ____________________

NAME(S) OF PERSON(S) **NOT** ALLOWED TO RECEIVE HEALTH INFORMATION FOR THIS PATIENT

______________________________ ______________________________ ______________________________