Patient's Name: _____ Gender: _____

Date of Birth: _____ Age: _____ Referred By: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Dentist: _____ Dentist #: _____

Spouse's Name: (If minor, parent's name): _____

Relationship to patient: _____ Employer: _____

Primary Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Guarantor (Name of person responsible for the financial account): _____

Date of Birth: _____ Age: _____ Social Security: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Relationship to patient: _____

Dental/Medical Insurance Information

Primary Dental Insurance Company Name: _____

Primary Subscriber Name: _____ Date of Birth: _____

Member ID # _____ Social Security #: _____

Group #_____ Employer: _____

Address for Claims: _____

Insurance Company Phone #: _____

Relationship to Patient: _____ Email: _____

Secondary Dental Insurance Company Name: _____

Primary Subscriber Name: _____ Date of Birth: _____

Member ID # _____ Social Security #: _____

Group #_____ Employer: _____

Address for Claims: _____

Insurance Company Phone #: _____

Relationship to Patient: _____ Email: _____

Primary Medical Insurance Company Name: _____

Primary Subscriber Name: _____ Date of Birth: _____

Member ID # _____ Social Security #: _____

Group #_____ Employer: _____

Address for Claims: _____

Insurance Company Phone #: _____

Relationship to Patient: _____ Email: _____