Patient Information

Patient Name: First_____ MI_____ Last_____

Preferred Name_____

Social Security No._____ - ____ - _____ Date of Birth_____/_____/_____

Address: Street_____

Apt/Unit/Suite_____ City_____ State_____ Zip_____

Phone: Mobile_____ Home_____

Work_____ E-Mail_____

What is your preferred method of contact?

□ Mobile Phone □ Home Phone □ Work Phone □ E-mail

Sex □ Male □ Female

Marital Status □ Married □ Single □ Divorced □ Separated □ Widowed

In case of emergency, who should be notified?_____

Relationship to Patient_____ Phone Number_____

Dental Benefit Plan Information

Primary Dental Plan Name of Insured_____

Birthdate_____SSN_____-____-_____

Insurance Company_____

Phone_____

Address: Street_____ City_____

State____ Zip_____

Dental Plan Name_____

Plan/Group Number_____

ID Number _____

Patient Relationship to Insured_____

Secondary Dental Plan Name of Insured_____

Birthdate_____SSN_____-____-_____

Insurance Company_____

Phone_____

Address: Street_____ City_____

State____ Zip_____

Dental Plan Name_____

Plan/Group Number_____

ID Number _____

Patient Relationship to Insured_____