Patient Information

First Name: Last Name:

Prefer to be called:_____ Gender:_____ Date of Birth:____/____/_____

Address: City/State/Zip:

Cell Phone: _____ Text Message Reminders OK? Y / N

Home: _____ Work: _____

Email: _____ Best time & number to reach you:_____

SSN: _____-_____-_____ Driver's License # _____

Emergency Contact Information:

Name:_____ Phone:_____ Relationship:_____

*If appointment is for **GENERAL DENTISTRY**, please fill in Dental Insurance Information:*

Dental Insurance Information (Primary)

Employer : _____
Insurance Company: _____
Ins Co Phone #: _____
ID Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber SSN: _____-_____-_____
Subscriber DOB: _____
Relationship to Patient: _____

Dental Insurance Information (Secondary)

Employer_____
Insurance Company: _____
Ins Co Phone #: _____
ID Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber SSN: _____-_____-_____
Subscriber DOB: _____
Relationship to Patient: _____

*If appointment is for **SLEEP APNEA or TMJ THERAPY**, please fill in Medical Insurance Information:*

Medical Insurance Information (Primary)

Employer: _____
Insurance Company: _____
ID Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber DOB: _____
Relationship to Patient: _____

Medical Insurance (Secondary)

Employer: _____
Insurance Company: _____
ID Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber DOB: _____
Relationship to Patient: _____

Financial Responsibility:

Name: _____ Gender: _____ Date of Birth: ____/____/_____
Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient: _____

How did you hear about our office? _____

_____ _____
Signature **Date**

Please Check One: ____ Adult Patient ____Parent/Guardian ____Spouse