

Patient: \_\_\_\_\_

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

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Dental Office: \_\_\_\_\_

How did you hear about us?

☐ I live/work in area ☐ I was referred by \_\_\_\_\_☐ Social media ☐ Other \_\_\_\_\_**INSURANCE INFORMATION**☐ No Dental Insurance☐ Primary Insurance

Name of Insurance Company: \_\_\_\_\_ State: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other \_\_\_\_\_

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\_\_\_\_\_  
Patient Signature\_\_\_\_\_  
Date