

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (M.I.)

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Male/Female Married/Single/Other

Phone(Home) \_\_\_\_\_ Phone(work) \_\_\_\_\_ Ext: \_\_\_\_\_ Spouse name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt #

City State Zip Code

Dentist: \_\_\_\_\_ Physician: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (if different than patient)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Dental Insurance:**

Insurance Plan Name: \_\_\_\_\_ Insurance Plan Address: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Is subscriber a patient here? yes No

Subscriber Birthdate: \_\_\_\_\_ ID# or SS# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's address: \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Insurance Plan Phone Number: \_\_\_\_\_ Relationship to patient: Self Spouse Parent Other \_\_\_\_\_

**Secondary Dental Insurance:**

Insurance Plan Name: \_\_\_\_\_ Insurance Plan Address: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Is subscriber a patient here? Yes No

Subscriber's Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Insurance Plan Phone Number: \_\_\_\_\_ Relationship to patient: Self Spouse Parent Other \_\_\_\_\_

**For office use only:**

Rep: \_\_\_\_\_ Max \_\_\_\_\_ Ded \_\_\_\_\_ per \_\_\_\_\_

Prev \_\_\_\_\_ Basic \_\_\_\_\_ Major \_\_\_\_\_ Intls. \_\_\_\_\_