Date _____

Title _____ First Name _____ M.I. ____ Last Name _____
Nickname_____ Date of Birth _____ Age ____ Soc. Sec. # _____
Address _____ City _____ State _____ Zip _____
Home Phone (  ) _____ Cell or 2nd # (**Required**) (  ) _____ Race _____

Employer: _____ Phone # _____ Marital Status _____

School_____ Full Time/Part Time

General Dentist _____ Referred By_____
Physician _____ Phone _____ Address _____

Emergency Contact _____ Phone _____ Address _____
Name, address & phone # of nearest relative not living with you: _____

## RESPONSIBLE PARTY INFORMATION (If other than Patient)

Name _____ Relationship to Patient _____
Address_____ Phone (  ) _____
Social Security # _____ Date of Birth_____
Employer _____
Employer Address _____ Phone (  ) _____

## MEDICAL & DENTAL INFORMATION MUST BE COMPLETED FOR US TO FILE CLAIMS ON YOUR BEHALF!

### PRIMARY DENTAL INSURANCE

Insurance Company _____
Group # _____
Employer _____
Name of Policy Holder_____
Policy Holder Date of Birth _____
Policy Holder ID # _____
Policy Holder Soc. Sec. # _____
Relationship to Patient _____

### SECONDARY DENTAL INSURANCE

Insurance Co _____
Group # _____
Employer _____
Name of Policy Holder _____
Policy Holder Date of Birth _____
Policy Holder ID # _____
Policy Holder Soc. Sec. # _____
Relationship to Patient _____

### PRIMARY MEDICALINSURANCE

Insurance Company _____
Group # _____
Employer _____
Name of Policy Holder _____
Policy Holder Date of Birth _____
Policy Holder ID # _____
Policy Holder Soc. Sec. # _____
Relationship to Patient _____

### SECONDARY MEDICAL INSURANCE

Insurance Co _____
Group # _____
Employer _____
Name of Policy Holder _____
Policy Holder Date of Birth _____
Policy Holder ID # _____
Policy Holder Soc. Sec. # _____
Relationship to Patient _____