Today's Date: _____

Patient Information

Patient Name: _____ Nickname: _____
Last Name First Name Middle

Mailing Address: _____
Street City State Zip

Home Address (If Different): _____
Street City State Zip

Patient Birthdate: _____ Social Security # (If patient over 18yrs old): _____

Primary Phone #: _____ Home ☐ Cell ☐ Work ☐ Secondary Phone #: _____ Home ☐ Cell ☐ Work ☐

Email Address: _____ How would you prefer to receive appointment reminders? Phone ☐ Text ☐ Email ☐

Gender: M ☐ F ☐ Non-Binary ☐ How did you hear about our office (if a patient, their name)?_____

Responsible Party/Guardian Information

*If this information is the same as above you may skip the next 4 lines and continue at the Employer information section.

Name: _____ Birthdate: _____
Last Name First Name Middle

Social Security #: _____ Relationship to Patient: _____

Mailing Address: _____
Street City State Zip

Primary Phone #: _____Home ☐ Cell ☐ Work ☐ Secondary Phone #: _____Home ☐ Cell ☐ Work ☐

*Employer: _____ Occupation: _____ # Years Employed: _____

Spouse Name: _____ Birthdate: _____ SS #: _____
Last First Middle

Spouse Primary Phone #: _____ HM ☐ Cell ☐ WRK ☐ Spouse Secondary Phone #: _____ HM ☐ Cell ☐ WRK ☐

Spouse Employer: _____ Occupation: _____ # Years Employed: _____

Dental Insurance Information

Subscriber Name: _____ Subscriber ID or SS #: _____

Subscriber DOB: _____Insurance Co. Name: _____ Insur Phone #: _____ Group #: _____

Subscriber Employer: _____ Subscriber Address (if different from patient): _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Subscriber Name: _____ ID or SS #: _____ Subscriber DOB: _____

Insur Co. Name: _____ Insur Phone #: _____ Employer: _____ Grp #: _____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____