WELCOME!

Who may we thank for referring you: ______________________________

Patient Information

Name: ____ Nickname: ___________________________ ☐Male ☐Female
Last First MI

Birth Date: ______/______/___________ Age: _________ SS#: ________-________-__________ Driver's license #: __________________________

Home #: (______)________-____________ Cell #: (______)_________-____________ Work #: (______)_________-_____________

Address: ____ E-mail: ____
Street
____ ☐ I would like to receive e-mail correspondences from this office
City CA Zip

Marital Status: ☐Single ☐Married ☐Divorced Previous/Present Dentist: ___________________________ Last Seen: ________________

Reason for today's visit: ___________________________________ Any problems with previous dental visits: _______________________________________

Parent Information (if patient is a minor)

Parent's Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed ☐Partnered ☐Separated

Mother's Information: ☐Stepmother ☐Guardian

Name: _____________________________ Birth Date: _______________

Home #: _____________ Cell #: ______________ Work #: ______________

Address: ____
Street
____
City State Zip

SS #: _____________________ Driver's License #: _________________

E-mail: ____

☐Responsible for account ☐Responsible for making appointments

Father's Information: ☐Stepfather ☐Guardian

Name: _____________________________ Birth Date: _______________

Home #: _____________ Cell #: ______________ Work #: ______________

Address: ____
Street
____
City State Zip

SS #: _____________________ Driver's License #: _________________

E-mail: ____

☐Responsible for account ☐Responsible for making appointments

Insurance Information

Primary Dental Insurance

Insurance Company Name: ____

Insurance Company Address: ______________________________________

Insurance Company Phone #: ______________________________________

Group #: ____

Policy Owner's Name: ____

Relationship to Patient: ____

Policy Owner's Birth Date: _______________ SS #: _________________

Policy Owner's Employer: ______________________________________

Employer's Address: ____

Secondary Dental Insurance

Insurance Company Name: ____

Insurance Company Address: ______________________________________

Insurance Company Phone #: ______________________________________

Group #: ____

Policy Owner's Name: ____

Relationship to Patient: ____

Policy Owner's Birth Date: _______________ SS #: _________________

Policy Owner's Employer: ______________________________________

Employer's Address: ____