

Today's Date: _____

Who referred you to this office? _____ Social Security #: _____

Patients Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Email: _____

Employer: _____ City: _____ Occupation: _____

Name of Spouse/Parent/Guardian: _____ Birthdate: _____
(Circle one)

Address if different: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Employer: _____ City: _____ Occupation: _____

In case of emergency, whom shall we notify other than spouse?

Name: _____ **Relationship:** _____ **Phone:** _____

INSURANCE INFORMATION **INSURANCE INFORMATION**

EMPLOYER: _____ EMPLOYER: _____

EMPLOYEE NAME: _____ EMPLOYEE NAME: _____

INS CO NAME: _____ INS CO NAME: _____

INS CO ADDRESS: _____ INS CO ADDRESS: _____

INS CO CITY: _____ ST: _____ ZIP: _____ INS CO CITY: _____ ST: _____ ZIP: _____

INSURANCE PHONE: _____ INSURANCE PHONE: _____

GROUP / POLICY #: _____ GROUP / POLICY #: _____

EMPLOYEE SS#: _____ EMPLOYEE SS#: _____

BIRTHDATE: _____ BIRTHDATE: _____

Patient Acknowledgements:

- I understand that I am responsible for any uninsured balance.
- If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.

I have read the above: Signature: _____ Date: _____
(Parent or Guardian if a minor)

PATIENT INFORMATION PART 1