PATIENT INFORMATION: **DATE: _____**

Patient's First Name: _____ MI _____Last Name: _____

Address _____ Home Phone ( ) _____

City _____State _____Zip_____ Cell Phone ( ) _____

Birth date _____ Social Security # _____ Work Phone ( ) _____

Male ( ) Female ( ) Single ( ) Married ( ) Divorced ( ) Other ( ) E-mail address: _____

Patient Employer_____City/State_____

In case of emergency contact: _____Phone # ( ) _____

BILLING INFORMATION:

Spouse or Parent Name _____Address_____
(Circle one) City/State/Zip_____

DOB _____ SS#_____ Home Phone ( ) _____Cell #_____

Employer _____ Work Phone ( ) _____

Other Parent Name_____ Address_____
City/State/Zip_____

DOB_____SS#_____ Home Phone ( ) _____Cell #_____

Employer_____ Address_____

DENTAL INSURANCE:

Primary Insurance Company Name & Address _____
Insured's Name _____DOB_____SS#_____
Secondary Insurance Company Name & Address_____
Insured's Name _____DOB_____SS#_____

THE POLICY IN OUR OFFICE IS THE PARENT WHO REQUESTS TREATMENT FOR THE MINOR IS RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED.