**PATIENT INFORMATION** **DATE** _____

**NAME** _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
Last First M

**SOCIAL SECURITY #** _____

**ADDRESS** _____
Street Apt # City State Zip

**BIRTHDATE** _____ **TELEPHONE** _____
Month Day Year Cell Home Work

**EMAIL** _____

**NAME OF EMPLOYER** _____ **ADDRESS** _____

**PERSON RESPONSIBLE FOR ACCOUNT** ☐ Patient ☐ Guardian ☐ Spouse ☐ Father ☐ Mother

Name _____ Phone _____

**INSURANCE INFORMATION** Minor child may need to complete both blocks for parent info; ADULTS complete primary insured; DUAL COVERAGE complete secondary insured

| **PRIMARY INSURED … If no insurance, complete for responsible party** | **SECONDARY INSURED** |
|---|---|
| _____<br>Last First M | _____<br>Last First M |
| _____<br>Street City State Zip | _____<br>Street City State Zip |
| _____<br>Cell Home Work E-mail | _____<br>Cell Home Work E-mail |
| _____<br>Birthdate (Month/day/year) Relationship to Patient | _____<br>Birthdate (Month/day/year) Relationship to Patient |
| _____<br>Employer Dental Insurance Company | _____<br>Employer Dental Insurance Company |
| _____<br>Social Security # Subscriber # Group # | _____<br>Social Security # Subscriber # Group # |

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name _____
Address _____
City/State/Zip _____
Telephone # _____

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

*Whom may we thank for referring you to our office?*

_____

## HIPPA Authorization To release information

I give permission to release verbal and or written information to :

Name_____ Relationship: _____

Name_____ Relationship: _____

Name_____ Relationship: _____