Date: _______________

Patient Information

First Name____________________________ Last Name____________________________ Middle Int.______

Address____ Apt. #____________

City____State______________________ Zip____________

Home Phone _________________________ Work Phone _________________________ Ext:_____________

Cell Phone ___________________________ Email____

For appointment confirmation, do you prefer: TEXT____ or EMAIL_____

Male____ Female____ Birth Date____________________ Age_____

Married____ Single____ Divorced____ Separated____

Soc. Sec. #_____________________________________

Student Status: Full Time ________ Part Time ________ School________________________________

Referred By____

Pharmacy____ Phone_________________________________

Primary Dental Insurance Information

Name of Insured____________________________________ Relationship to Insured______________________

Insured Soc. Sec. #__________________________________ Insured Birth Date__________________________

Employer_______________________________________ Address____________________________________

Insurance Co.____________________________________ Address____________________________________

ID #______________________________ Group #___________________________

Secondary Insurance Information

Name of Insured____________________________________ Relationship to Insured______________________

Insured Soc. Sec. #__________________________________ DOB____________

ID #___________________________ Group #_________________ Employer____________________________

Insurance Co.________________________________ Address____