

PATIENT INFORMATION

PATIENT'S NAME Last First Middle Initial SEX: M F BIRTHDATE AGE
Soc. Sec. # If Patient is a Minor, give Parent's or Guardian's Name TODAY'S DATE
Who May We Thank for Referring You to our Office? Reason for this Visit

RESPONSIBLE PARTY INFORMATION

NAME Last First Middle Initial MARITAL STATUS
RESIDENCE Street Apt. # City State Zip
MAILING ADDRESS Street Apt. # City State Zip
HOW LONG AT THIS ADDRESS HOME PHONE CELL PHONE
WORK PHONE E-MAIL
PREVIOUS ADDRESS (if less than 3 yrs.) Street City State Zip How Long
SOCIAL SECURITY # BIRTHDATE DRIVER'S LICENSE # RELATION TO PATIENT
EMPLOYER OCCUPATION NO. YEARS EMPLOYED

RESPONSIBLE PARTY'S SPOUSE

NAME LAST FIRST MIDDLE
EMPLOYER OCCUPATION NO. YEARS EMPLOYED
SOC. SEC. # BIRTHDATE
HOME PH. CELL PH.
WORK PH. E-MAIL

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME RELATIONSHIP
ADDRESS CITY, STATE
HOME PH. CELL PH.
WORK PH.

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name
Insurance Co. E-MAIL
Insurance Co. Address
Insured's Employer
Insured's Soc. Sec. # Group # Local #

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name
Insurance Co. E-MAIL
Insurance Co. Address
Insured's Employer
Insured's Soc. Sec. # Group # Local #

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Table with columns for DENTAL HISTORY and MEDICAL HISTORY, containing various health questions and checkboxes for YES/NO.

PATIENT Signature (Parent of Child)

Date:

DENTIST Signature