

Today's Date _____

Name _____ Name I like to be called _____

Mailing Address _____ City _____ Zip _____

Street Address _____ City _____ Zip _____

Birthdate _____ Marital Status _____ SS# _____ E-mail _____

Hm# () _____ Wk # () _____ Ext. _____ Cell # () _____

Occupation _____ Employer _____

Spouse's or Parent's Name _____ Birthdate _____ SS# _____

Spouse's or Parent's Occupation _____ Spouse's or Parent's Employer _____

Contact Phone Number () _____

PERSON RESPONSIBLE FOR ACCOUNT

Check if same as above: proceed to next section

Name _____ SS# or ID# _____

Address _____ City _____ Zip _____

Relationship to Patient _____ Birthdate _____

Employer _____ Work Phone () _____

DENTAL INSURANCE

Employee Name _____ Birthdate _____

Insurance Company _____ Customer Service # _____

Employer _____ Group# _____

GETTING TO KNOW YOU

Please list the members of your family that are patients in our office: Names: _____

How did you hear about our office? Yellow Pages Website Mailer Sign

Other _____ Friend/Family _____

Person to contact in case of emergency (not living with you)

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____