## Patient Information

**Patient's Name** _____
**Last** **First** **Middle**

Address_____
Street Apt#

_____
City State Zip

Birth Date_____SSN#_____

Drivers Lic.#_____Home Ph._____Email Address_____

Marital Status_____Male_____Female_____

Work Ph._____Cell Ph._____Employer_____

Employer's Address_____

Spouse's Name_____
**Last** **First** **Middle**

Spouse's Employer_____Spouse's Work Ph._____

Is an immediate family member a patient here? _____

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

**Responsible Party Information** Self_____ Other_____

If "Other". Name_____
**Last** **First**

Address_____
Street Apt# City State Zip

Birth Date_____Social Security #_____

Home Ph._____Work Ph._____Relationship to Patient_____

**Do you have Dental Insurance? Yes_____ No_____**

**Emergency Information**

Name_____Address_____ Ph.#_____

**We appreciate your cooperation in giving our office a 24 hour notice if you need to change your reserved appointment time. Then no fee will result. I understand that, when appropriate, credit reports may be obtained. I direct insurance benefits payable to the attending dentist.**

_____Signature _____ Date