

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ email address: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

**Referral Information**

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
Name of person or office referring you to our practice: \_\_\_\_\_

**Responsible Party Information**

The following is for:  the person responsible for payment  
Name: \_\_\_\_\_  
 Male  Female  Married  Single  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street  
City State Zip Code

**Responsible Party Employment Information**

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City, State Zip Code Phone

**Insurance Information**

**Primary**  
Name of Insured: \_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address (if different from above): \_\_\_\_\_  
Street City State Zip Code  
Insured's Employer Name (if different from above): \_\_\_\_\_  
Address: \_\_\_\_\_  
Street State Zip Code  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
**Secondary**  
Name of Insured: \_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street City State Zip Code  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: \_\_\_\_\_