PATIENT INFORMATION

Date________________

Legal Name: First: _____________________________ M.I. _______ Last: _________________________________

Prefers to go by: _____________________________ Patient's **SS #**_____________________________

Birth Date__________________________ Name & Relationship of **Guardian** ____________________________

Home Address:____

Street City State Zip

Home phone: (_____) ____________________________ **Work:** (_____) ___________________________________

Cell: (______)___________________________ **Email address**:______________________________________

Driver's License #____________________________

How would you prefer we **contact** you? Email_____ Cell_____ Home_____ Work______

Patient's or Guardian's **Employer:**______________________________ **Occupation**:__________________________

Work Address:____ Yrs. Employed:_________________

Spouse's First Name: ________________________ M.I.: _______ Last: ______________________________________

Spouse's Employer:____________________________________ Occupation:___________________________________

Spouse's SS#:______________________ Birth Date:_________________________ Cell: (____)____________________

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

Have any other family members been to this office? **Y or N** If so, whom? __________________________________

INSURANCE INFORMATION

Insured's Name____________________________ Group Number:____

Insured ID: ____________________________________Insured SS #: ____

Insured's Date of Birth____________________________ Do you have dual coverage? Yes________ No________

EMERGENCY INFORMATION

Emergency Contact Person: ____

Home Phone: (_____)_________________________ Alternate Phone: (______)_________________________________

Relationship to Patient: ____

Address: ____

Street City State ZIP

I understand I am **responsible for my account**. If I have dental insurance the claims will be filed for me, and I will be responsible for any remaining balance. I also understand this office values my time and will make every effort to honor my appointment times. Likewise if I fail to keep my appointments without **24 hours notice**, I understand I will be billed the cancellation fee, or possibly be dismissed from the practice if this policy is violated repeatedly. If you are the parent or guardian of a minor child and are bringing them for treatment in this office, you are responsible for the child's balance.

Signature ____ Relationship to Patient:_________________________