PATIENT INFORMATION - CONFIDENTIAL

Patient Full Name*

Nickname

Patient Birth Date*
mm/dd/yyyy

Parent or Guardian
If patient is a minor

Mailing Address

Physical Address
If Different than Mailing Address

Home Phone

Work Phone

Mobile Phone

Employer

Spouse

Spouse's Phone

Spouse's Birth Date

Spouse's Employer

Emergency Contact Name

Phone

Dental Insurance

Address

Phone

ID #

Group #

I understand that dental insurance is a contract between me, my insurance company, and my employer. I will assume all responsibility for the charges regardless of insurance coverage. I understand that payment is expected at the time of service unless prior arrangements have been made. All accounts over 90 days are subject to an interest charge. There will be a return check fee on non-sufficient funds of $35.00.

*Please note - Patient's Social Security number and signature will be required at time of appointment.

SIGNATURE

Type your full name

DATE

mm-dd-yyyy