Date _____ **Confidential Patient Information** A B C

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate_____ Social Security # _____

Dentist _____Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Cell Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ Years Employed _____

Social Security # _____ Birthdate _____ Cell Phone _____

Dental Insurance Information Only

Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group No. _____ Birthdate _____

Employer _____ _____ Please present card for verification.

Emergency Information

Name of nearest relative not living with you/Relationship _____

Complete Address _____ Phone No _____

I understand that where appropriate, credit bureau reports may be obtained. Date _____

Signature (Parent's signature if minor) _____