How did you hear about us?______________________________Today's Date________________

Patient Information:

Last Name:________________________First Name:_____________ _________Middle Initial: ______

Address:________________________________City:__________________ST:______Zip:____________

Home Phone:________________Work Phone:_________________Mobile Phone:_______________

Email Address:_____________________What is the best way to contact you?_________________

Marital Status:_______ Sex: M F Birth Date:____________Social Security #:__________________

Patient or Parent's Employer: ____

Emergency Contact Name:________________Emergency Contact Number:__________________

Medical Doctor:__________________________Doctor's Phone #:____________________________

Responsible Party (If patient is under 19):

Last Name:________________________First Name:__________________________Middle Initial:______

Address:_______________________________________City:___________________ST: ___Zip:__________

Relation to Patient:____

Home Phone:__________________Work Phone:________________Mobile Phone:__________________

Dental Insurance Information: Verified ☐

Name of Insured:________________________________Relationship to patient:________ _______

Policy Holder's Social Security #:_____________________Policy Holder's Date of Birth:______________

Name of Insured's Employer:___________________________Phone # of Employer:_________________

Insurance Company: ________________________________Policy Number:_______________________

Claim Filing Address:____

Group Number:__________________________Group Name:___________________________________

Medicaid Number (if applicable):_______________________