

Patient Information

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City, State, Zip Code)

Home # (____)____-____ Work # (____)____-____ Cell/Pager # (____)____-____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-____-____

Circle One: Single Married Divorced Widowed Email : see medical history form

Employer Name and Address _____ Phone: _____

Job Title/Occupation _____ Date Started _____

Name of closest relative not living with you _____

Relative's Address _____
(Street) (City, State, Zip Code)

Relationship _____ Home # (____)____-____ Cell Phone# (____)____-____

Spouse Information

Last Name _____ First Name _____ MI _____

Address (if different): _____
(Street) (City, State, Zip Code)

Home # (____)____-____ Work # (____)____-____ Cell/Pager # (____)____-____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-____-____

Email : _____

Employer Name and Address _____ Phone: _____

Job Title/Occupation _____ Date Started _____

Insurance Information

Name of Insured _____

Employee SSN _____-____-____ Birth Date ____/____/____ Relationship _____

Insurance Company Name & Address _____

Insurance Company Phone # _____ Policy/ Group # _____

Secondary Insurance Name of Insured _____

Employee SSN _____-____-____ Birth Date ____/____/____ Relationship _____

Insurance Company Name & Address _____

Insurance Company Phone # _____ Policy/Group # _____

Additional Information

How did you find out about our office? _____

What is the reason for your visit with us today? _____

Is there anything about your smile that you would like to improve? _____

Patient Signature _____ Print Name _____

Responsible Party _____ Relationship _____