Personal Information

Name___________________________
I prefer to be called_______________
Single ________Married___________
Male_________ Female ___________
Birth date _______________________
Social security # _________________
Home address ____________________
Home phone ______________________
Work phone ______________________
Cell phone _______________________
Email address ____________________
How do you prefer to be confirmed?
Home phone   Cell phone   Email

Other family members seen by us
____

Referred by _______________________

Person responsible for account _______
Relationship______________________
Social security #___________________
Home phone_______________________
Work phone_______________________
Billing address_____________________

Are you currently under the care of a physician? _______________________
Physician's name__________________
Physician's phone # ________________
Are you currently taking any prescription or over the counter drugs?
Please list _________________________
Do you smoke or use tobacco in any form? Yes________ No____________

For women only: Are you pregnant? _______________ Nursing__________________________
Are you taking birth control pills? Yes________________ No ______________________________

Insurance Information

Primary:
Dental coverage: Yes_____ No_______
Insurance Co. name ________________
Insurance Co. address ______________
____
Insurance Co. phone #______________
Group # _________________________
Insured's name ____________________
Relationship ______________________
Insured's date of birth ______________
Insured's social security #___________
Insured's employer ________________

Secondary:
Dental coverage**: Yes**______ **No**_____
Insurance Co. name________________
Insurance Co. address_______________
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Insurance Co. phone #______________
Group #_____________________________
Insured's name ___________________
Relationship _______________________
Insured's date of birth_______________
Insured's social security #___________
Insured's employer ________________