



**Welcome to our Practice! Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.**

**Patient Information**

Date \_\_\_\_\_ Patient Name \_\_\_\_\_  
First Name Middle Initial Last Name

Date of Birth \_\_\_\_\_ Male/Female SS# \_\_\_\_\_ Drivers License # \_\_\_\_\_  
Month Day Year

**How did you hear about us?** \_\_\_\_\_ Status: Married, Single, Divorced, Widowed

Email \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone# \_\_\_\_\_

**Responsible Party** \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

**Primary Insurance Information**

Subscriber or Policy Holders Name \_\_\_\_\_  
First Name Middle Initial Last Name

Subscriber or Policy Holders Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Month Day Year

Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

Employer or Company Name \_\_\_\_\_

Dental Insurance Co. Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to Patient: (Self Spouse Father Mother Guardian)

**Secondary Insurance Information**

Subscriber or Policy Holders Name \_\_\_\_\_  
First Name Middle Initial Last Name

Subscriber or Policy Holders Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Month Day Year

Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

Dental Insurance Co. Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to Patient: (Self Spouse Father Mother Guardian)