

**PATIENT**

PATIENT LAST NAME		FIRST	MIDDLE	PREFERRED NAME TO BE CALLED	TODAY'S DATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
BIRTH DATE	M.	D	YR	SOCIAL SECURITY NUMBER		HOME PHONE	<input type="checkbox"/> NONE MESSAGE PHONE
MAILING ADDRESS				CELL PHONE	CITY	STATE	ZIP CODE
HOME ADDRESS <input type="checkbox"/> SAME		APT. OR SPACE NO.		CITY	STATE	ZIP CODE	
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU			RELATIONSHIP	PHONE ( )	ADDRESS		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?						RELATIONSHIP	

**RESPONSIBLE PARTY (PLEASE FILL OUT COMPLETELY) FINANCIAL RESPONSIBILITY**

PERSON RESPONSIBLE		LAST NAME	FIRST	MIDDLE	RELATIONSHIP		
HOME PHONE	<input type="checkbox"/> SAME		SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER	STATE	
HOME ADDRESS <input type="checkbox"/> SAME AS ABOVE				CITY	STATE	ZIP CODE	
EMPLOYER	<input type="checkbox"/> SELF	<input type="checkbox"/> NONE	<input type="checkbox"/> RET	BUSINESS ADDRESS		BUS. PHONE	OCCUPATION

**IF PATIENT IS UNDER AGE 21**

FULL TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	SCHOOL ATTENDING	CITY	GRADE
BOTH PARENTS NAMES		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa FINANCIAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa

**PRIMARY DENTAL INSURANCE  NONE**

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME		FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	

**SECONDARY DENTAL INSURANCE  NONE (If, Turn Page Over)**

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME		FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	