

We would like to get to know you better!

Name: _____ ☐ Male ☐ Female

Date of Birth: _____ If child, parent's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Occupation: _____

Employer: _____

Preferred Pharmacy for prescriptions: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced

Preferred method of contact: ☐ Phone ☐ Email ☐ Text

Spouse Information (If Applicable)

Name: _____

Occupation: _____

Employer: _____ Work Phone: _____

Responsible Party Information:

Name: _____

Date of Birth: _____ Social Security #: _____ Driver's License St. and #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

Primary Insurance Details:

Date of Insured: _____ Group #: _____ Member ID #: _____

Name of Insured: _____ Relationship to Patient: _____

Insured SSN: _____ Employer Name: _____

Insured Address: _____ Insurance Company: _____

Who can we thank for referring you to our office? _____

Person responsible for dental investment: _____