1. PATIENT INFORMATION

ADULT

Name ______________________

Birthdate__________ SS# __________

Phone ( ) ______________________

Address ______________________

City ______________________

State ______________ Zip ______

Employed by ______________________

Employer's address ______________________

Work phone ( ) ______________________

Person to notify in case
of emergency ______________________

Relationship ______________________

Daytime Phone ( ) ______________________

Physician ______________________

Referred by ______________________

CHILD

Name ______________________

Birthdate__________ SS# __________

Phone ( ) ______________________

Address ______________________

City ______________________

State ______________ Zip ______

Student Yes [ ] No [ ]

School______________________

Person responsible
for child ______________________

Relationship ______________________

Daytime Phone ( ) ______________________

Address if different
from above______________________

Physician ______________________

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE.

2. DENTAL INSURANCE

PRIMARY

Dental Insurance Co. ______________________Group # ______________________

Address ______________________

Employee ______________________Social Security # ______________________

Employer ______________________

Employer Address ______________________

Work Phone ( ) ______________________ Birthdate ______________________

SECONDARY

Dental Insurance Co. ______________________Group # ______________________

Address ______________________

Employee ______________________Social Security # ______________________

Employer ______________________

Employer Address ______________________

Work Phone ( ) ______________________ Birthdate ______________________