Date: _____ **Name:** _____ **DOB:** _____

Personal Information

Questions	***Answers***
I prefer to be called:	
Person to Contact in Case of an Emergency?	
PATIENT INFORMATION. Home Address:	
City/State/Zip:	
Home Phone:	
Work Phone:	
Cell Phone:	
E-mail:	
Prefered mode of contact:	Home phone
	Cell phone
	Work phone
	E mail
Spouse or Parent's Name:	
Patient's or Parent's Employer:	
Business Address:	
City/State/Zip:	
Whom may we thank for referring you?	
How did you find out about our office?	Insurance
	Internet
	Phone book
	Promotion
	Friends
	Referred by a Dentist
RESPONSIBLE PARTY. Same as above?	Yes
	No
Driver's License#:	
Date of Birth:	
SSN (for US) / SIN (for Canada):	
PRIMARY INSURANCE INFORMATION. Name of Insured:	
Relationship to Patient:	Self
	Parent
	Grandparent
	Guardian
	Family member
	Relative
	Other
Date of Birth:	
SSN (for US) / SIN (for Canada):	
Employer:	
City/State/Zip:	
Insurance Company:	
Group #:	

Date: _____ **Name:** _____ **DOB:** _____

Personal Information

Questions	***Answers***
Policy/ID#:	
Ins Company Address:	
City/State/Zip:	
How much is your deductible?	
How much have you used?	
Max. Annual Benefit:	
Do you have any additional insurance? IF Yes, please complete the following.	Yes
	No

Signature: _____