Patient Personal Information

Title _____ Nickname_____ Birth Date _____ Age _____
Last, First _____ Marital Status _____Gender _____
Address _____ Home # _____Work #_____
_____ Cell # _____Drive Lic_____
City, State, Zip _____ Student _____SSN _____
Email _____ School Name _____
_____ How did you hear about our practice? _____
Is patient responsible for paying bills? ☐Yes ☐No

Person responsible/guarantor for paying bills

Title _____ Nickname_____ Birth Date _____ Age _____
Last, First _____ Marital Status _____Gender _____
Address _____ Home # _____Work #_____
_____ Cell # _____Drive Lic_____
City, State, Zip _____ SSN _____
Email _____

Dental Insurance

Do you have **Primary** Dental Insurance? ☐Yes ☐No
Group No./Name_____
Insurance Name_____
Phone # _____
Employer Name_____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____
Birth Date _____
Subscriber ID _____

Do you have **Secondary** Dental Insurance? ☐Yes ☐No
Group No./Name_____
Insurance Name_____
Phone # _____
Employer Name_____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____
Birth Date _____
Subscriber ID _____