Whom may we thank for referring you to us? _____

Patient Information

(Please Print)

Name _____ Date _____ Social Security Number _____
First MI Last

Email _____ Driver's License Number _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home Phone # _____ Work Phone # _____

Cell Phone # _____ Do you prefer to receive calls at ❑ Home ❑ Work ❑ Cell ❑ Any

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work Phone # _____

If you are a student, name of school/college _____ City _____ State _____

Person to contact in case of an emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co _____ Group # _____ Employer # _____

Insurance Co Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

On a Scale of 1-10 – How would you rate your smile? _____

What would make it a "10"? _____

Do you want us to discuss this? _____