THE FOLLOWING CONFIDENTIAL INFORMATION IS NECESSARY TO SERVE YOU MORE EFFICIENTLY AND TO PROCESS YOUR DENTAL INSURANCE. (Please print.)

PATIENT'S NAME	LAST, FIRST, MIDDLE	
RESIDENCE ADDRESS	STREET	
CITY		ZIP CODE
PHONE NUMBER (is this a cell?)	DATE OF BIRTH	AGE
SOCIAL SECURITY NUMBER (18+)		DRIVERS LICENSE NUMBER
PATIENT EMPLOYED BY		PHONE NUMBER
BUSINESS ADDRESS		
OCCUPATION	UNION NAME	LOCAL NUMBER
IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY? NAME & PHONE NUMBER		

PHYSICIAN'S NAME____ PHONE NUMBER_______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

IF PATIENT IS INSURED, COMPLETE THIS PORTION

PRIMARY DENTAL INSURANCE	NAME OF POLICY HOLDER	ID NUMBER OR SOCIAL SECURITY NUMBER
EMPLOYER	DATE OF BIRTH	GROUP NUMBER
SECONDARY DENTAL INSURACE	NAME OF POLICY HOLDER	ID NUMBER OR SOCIAL SECURITY NUMBER
EMPLOYER	DATE OF BIRTH	GROUP NUMBER

IF PATIENT IS MARRIED, COMPLETE THIS PORITON

NAME OF SPOUSE	DATE OF BIRTH	PHONE NUMBER
EMPLOYED BY	CITY	

IF PATIENT IS A MINOR

PARENT OR RESPONSIBLE PARTY	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SIGNED____ **DATE** ______________________________

PRINTED NAME ____

Relationship to patient if patient is a minor or mentally handicapped ____