PATIENT INFORMATION

DATE _____

(Please Print)

Patient Name _____ **Circle One: Male Female**
Title (Miss,Mrs.,Ms., Dr.) Last First Middle Initial

Home Address _____
Street City State Zip Code

Date of Birth ___/___/_____ **Martial Status**_____ **Social Security Number**_____

Home Phone ( ) ____-_____ **Work Phone** ( ) ____-_____ **Cell Phone** ( ) _____-_____

Phone Number to Confirm ( ) ___-_____ **Email** _____

Employer_____ **Occupation**_____

Person to Call In Case Of Emergency _____

Who is responsible for Payment? If not patient enter information for this person (The Guarantor)

Guarantor Name_____ **Home Phone** ( ) ___-_____
Title (Miss, Mrs., Mr., Dr.) Last First Middle Initial

Home Address _____
Street City State Zip Code

Home Phone ( ) ____-_____ **Date of Birth** _____**Martial Status** ____

Social Security Number _____ **Employer** _____

Occupation _____**Work Phone** ( )___-_____ **Cell Phone** ( )____-_____

DO YOU HAVE DENTAL INSURANCE? Yes or No

If Insured, we need a copy of your INSURANCE CARD on file

Insurance Subscriber is (circle one) Patient or Guarantor or Other (If other enter information below)

Name of Insured _____ **Relationship to Patient** _____

Home Address_____
Street City State Zip Code

Date of Birth ___/___/_____ **Social Security Number** _____**Home Phone** ( ) ____-_____

Marital Status _____ **Employer** _____ **Occupation**_____

Work Phone ( ) _____-_____ **Cell Phone** ( ) _____-_____

WHOM MAY WE THANK FOR REFERRING YOU? OR WHERE DID YOU HEAR ABOUT OUR OFFICE?

_____

PAYMENT OF CHARGES ARE DUE AT THE TIME SERVICE IS RENDERED! PLEASE INDICATE METHOD OF PAYMENT:

CASH _____ **CHECK** _____**VISA** _____ **M/C** _____**DISCOVER** _____**AMEX** _____**CARE CREDIT** _____