

## Patient Information

Chart #.

FOR OFFICE USE ONLY

Patient Name:      
Last First MI Preferred Name

Title:  Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other  
Mr/Ms/Mrs/etc

Birth Date:  SS #:  Prev. Visit:

Email Address:  Best time to call:

Phone:        
Home Work Ext Mobile Fax Other

Address:    
    
City State Zip Code

Whom may we thank for referring you to our office?

## Employer Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:  Phone:

Address:    
    
City State Zip Code

## Responsible Party

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name:      
Last First MI Preferred Name

Title:  Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other  
Mr/Ms/Mrs/etc

Birth Date:  SS #:  Driver's License #:

Email Address:  Best time to call:

Phone:        
Home Work Ext Mobile Fax Other

Address:    
    
City State Zip Code

## Northern Information if applicable

What months are you up north?

Address:

Phone:

Do you see a Dentist up north?

☐ Yes ☐ No

If you see a dentist up north, please fill out Season Information Form

### Dental Insurance Information ( Primary )

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

I (the patient) understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: \_\_\_\_\_

Date:

Response Date: