

## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

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: \_\_\_\_\_ Prev. Visit: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Home Mobile Work Ext

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Preferred appointment times:  
 Mon  Tue  Wed  Thur  Fri  Sat  Morning  Afternoon  Evening  Any time

Whom may we thank for referring you to our practice?  
 Dental Office  Yellow Pages  Internet  Newspaper  School  Work  
 Other (name below): \_\_\_\_\_

Name of person, office, or other source referring you to our practice:  
\_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment  both  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: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Home Mobile Work Ext

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

Spouse or Responsible Parties Social Security Number \_\_\_\_\_

## Employment Information

The following is for:  the patient  the person responsible for payment  both  not applicable

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

### Primary Insurance Information

#### Primary Dental Insurance:

Name of Insured: \_\_\_\_\_  
Last First MI

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

Insured's Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
Address 1 Address 2  
\_\_\_\_\_  
City State Zip Code

Response Date: \_\_\_\_/\_\_\_\_/\_\_\_\_