How did you hear about us?_____**Today's Date**_____

Patient Information:

Last Name:_____First Name:_____Middle Initial:_____

Address:_____City:_____ST:_____Zip:_____

Home Phone:_____Work Phone:_____Mobile Phone:_____

Email Address:_____What is the best way to contact you?_____

Marital Status:_____ Sex: M F Birth Date:_____Social Security #:_____

Patient or Parent's Employer: _____

Emergency Contact Name:_____Emergency Contact Number:_____

Medical Doctor:_____Doctor's Phone #:_____

Responsible Party (If patient is under 19):

Last Name:_____First Name:_____Middle Initial:_____

Address:_____City:_____ST: ___Zip:_____

Relation to Patient:_____

Home Phone:_____Work Phone:_____Mobile Phone:_____

Dental Insurance Information:

Verified ☐

Name of Insured:_____Relationship to patient:_____

Policy Holder's Social Security #:_____Policy Holder's Date of Birth:_____

Name of Insured's Employer:_____Phone # of Employer:_____

Insurance Company: _____Policy Number:_____

Claim Filing Address:_____

Group Number:_____Group Name:_____

Medicaid Number (if applicable):_____