



**Patient Information**

A B C

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ M / F  
Last First Middle Preferred First Name Sex

Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ Referred By \_\_\_\_\_

Patient's Physician \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ Other family members in treatment \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

E-Mail \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_