Patient Information	
	Date:
Patient Name:	
Patient Name: Last First DOP: SS#:	MI Preferred Name
DOB: SS#: SS#:	Driver's License #
Address:City:	State: Zip:
Telephone: (Home)	(Work)
(Cell)	(Other)
(E-Mail)	Best time to call:
Employed By: Sex: F_ M_ Marital Status: Married_ Single	Position:
Sex: F M Marital Status: Married Singl	e Divorced SeperatedWidowed
Responsible Party	
Patient Name:	
DOB:SS#:	Driver's License #
Address:City:	State: Zin:
Telephone: (Home)	(Work)
	(Other)
(E-Mail)	Best time to call:
Sex: F M Marital Status: Married Single	e Divorced SeperatedWidowed
Employed By:	Position:
Insurance Information	
Name of Insured:	
Insured's DOB:ID#:	Group #:
Insured's AddressStreet	City ST Zip
Insured's Employers Name: Patients relationship to insured: SelfSpouse	Child Other
Insurance Company Name:	Phone#:
Address:	
Consent	
I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this I attest to the accuracy of the information on this page.	
Patient or Guardian Signature:	Date
Whom May We Thank For Referring You:	