

# Welcome!

## Patient Information

Name: \_\_\_\_\_ Home Ph: \_\_\_\_\_ Cel Ph: \_\_\_\_\_  
Date: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Male / Female (please circle)  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_  
Work Ph: \_\_\_\_\_ May we call you at work? \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## Spouse Information

Name: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_  
Business Phone: \_\_\_\_\_ Cel Ph: \_\_\_\_\_

## Person Responsible for Account

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address (if different from Patient's): \_\_\_\_\_ Business: \_\_\_\_\_  
Phone: \_\_\_\_\_ Birthday: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Cel # \_\_\_\_\_

## Dental Insurance

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_ Insurance address: \_\_\_\_\_  
Subscribers ID \_\_\_\_\_ Group# \_\_\_\_\_ SS# \_\_\_\_\_  
Insured Employer: \_\_\_\_\_ Insured Birthday: \_\_\_\_\_

## Secondary Insurance

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_ Insurance Address: \_\_\_\_\_  
Subscribers ID# \_\_\_\_\_ Group #: \_\_\_\_\_ SS# \_\_\_\_\_  
Insured Employer: \_\_\_\_\_ Insured Birthday: \_\_\_\_\_