Patient Name: _____ Home Phone: (_____)_____-_____

Address: STREET_____ Mobile Phone: (_____)_____-_____

CITY_____ STATE_____ ZIP _____ Work Phone: (_____)_____-_____

Sex: _____Birthday (DOB): _____ /_____ / _____ Marital Status: _____ Social Security #: _____ - _____ - _____

Patient E-mail: _____

Preferred Method of Contact: ◯ **TEXT** ◯ **EMAIL** ◯ **PHONE CALL**

Dental Insurance Co: _____ Insurance phone: (_____) _____- _____

Policyholder Name: _____Employer Name: _____

Social Security number / ID: _____

Policyholder Relationship to Patient: _____Policyholder DOB: _____/_____/_____Group#: _____

Secondary Insurance Co: _____ Insurance phone (_____) _____- _____

Policyholder Name: _____Employer Name: _____

Social Security number / ID: _____

Policyholder Relationship to Patient: _____Policyholder DOB: _____/_____/_____Group#: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP_____

PRIMARYPHONE: (_____) _____-_____ SECONDARY PHONE: (_____) _____-_____

Who is Financially Responsible? _____ Phone number: (_____) _____ - _____

What name do you prefer we address you by? _____

How did you hear about our office? _____

Is there anything you would like to change about your smile? _____

Who is your favorite Musician / Band? _____