Patient Name_____ Date_____

Address_____ DOB_____

City, State, Zip_____ SSN_____

Home phone_____ If under 18 years old:

Cell_____ Father's DOB_____

Work_____ Mother's DOB_____

Email_____

Would you like to receive text message for appointment confirmations? **Yes** or **No**

Dental Insurance Information

Insurance for this patient is provided by:

Myself Spouse Both Parent

Primary

Subscriber Name_____

SSN_____

Employer_____

Insurance Co_____

Phone #_____

Group/Policy #_____

Contract ID #_____

Secondary

Subscriber Name_____

SSN_____

Employer_____

Insurance Co_____

Phone #_____

Group/Policy #_____

Contract ID #_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED_____

Phone #_____ Relation to patient_____