CONFIDENTIAL PATIENT INFORMATION

(Please Print Legibly)

Date_____

PERSONAL INFORMATION

Name:_____ SS#:_____
Address:_____
City:_____ State:_____Zip:_____
Telephone: (Home) _____(Work) _____
(Cell) _____ e-mail:_____
Birthday:_____ Sex:_____ Marital Status:_____ Spouse Name:_____
Employer:_____Referred by:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ Relationship:_____SS#:_____
Address: _____DOB: _____
City:_____ State:_____Zip:_____
Telephone: (Home) _____ (Work)_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co._____
Insurance Co. Address:_____
Employee: _____Relationship:_____SS#:_____
Employer:_____Policy #:_____
Secondary Insurance Co._____
Insurance Co. Address:_____
Employee:_____Relationship:_____SS#:_____
Employer: _____Policy #:_____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE:	**DATE:**