



**ABOUT YOU**

All information required.

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_ (M) \_\_\_\_\_  
Last Name \_\_\_\_\_  
I prefer to be called \_\_\_\_\_ M \_\_\_ F \_\_\_  
Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
 Single  Married  Divorced  Widowed  
**Circle yes or no please:**  
Facebook: Yes / No Twitter: Yes / No  
Text Messaging: Yes / No  
Home # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_  
Work # (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Other # (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
How long there? \_\_\_\_\_ Occupation \_\_\_\_\_  
Last Dental Visit \_\_\_\_\_

**How did you hear about our office?**

\_\_\_\_\_

**SPOUSE INFORMATION**

His/Her Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Work # (\_\_\_\_) \_\_\_\_\_ Cell#(\_\_\_\_) \_\_\_\_\_  
SS# \_\_\_\_\_  
Birthdate \_\_\_/\_\_\_/\_\_\_ CDL# \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name \_\_\_\_\_  
Billing Address \_\_\_\_\_  
\_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
SS# \_\_\_\_\_ CDL# \_\_\_\_\_  
Employer \_\_\_\_\_  
Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

**INSURANCE COVERAGE**

**Primary**

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_  
Group or Plan # \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured's Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_  
Insured's ID # \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

**Secondary**

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insurance Co. Phone # (\_\_\_\_) \_\_\_\_\_  
Group or Plan # \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured's Birthdate \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_  
Insured's ID # \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

In the event of an emergency, is there someone who lives near you that we should contact?

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home # (\_\_\_\_) \_\_\_\_\_ Wk# (\_\_\_\_) \_\_\_\_\_

**MEDICAL HISTORY**

Do you have a personal Physician?  Yes  No  
Physician's Name \_\_\_\_\_  
Phone # (\_\_\_\_) \_\_\_\_\_  
Date of last visit \_\_\_\_\_  
Are you currently under the care of a physician?  Yes  No  
Please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

**Please Turn Over----->**