Today's Date:

Complete front and back of all forms. Please use a black ink pen.

Patient Information

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws.

NAME: Last	First	Middle	(Preferred Name)	Date of Birth:

⍒ Male ⍒ Married ⍒ Single
⍒ Female ⍒ Child ⍒ Other _____

Social Security #: Driver's License #:

Home Address:	Apartment #:	Mailing Address: **(Please complete if different than Home address.)**
City: State: Zip Code:		City: State: Zip Code:

Home Phone: include area code	Work Phone: include area code	Ext:	E-Mail Address:
( )	( )		
Cell Phone: include area code	Fax Phone: include area code		Other Phone: include area code
( )	( )		( )

Person Responsible For Account/Payment

Is this Person Currently a Patient in our office? ..... ⍒ Yes ⍒ No

NAME: Last	First	Middle	(Preferred Name)	Date of Birth:

⍒ Male ⍒ Married ⍒ Single
⍒ Female ⍒ Child ⍒ Other _____

Social Security #: Driver's License #:

Home Address:	Apartment #:	Mailing Address: **(Please complete if different than Home address.)**
City: State: Zip Code:		City:State:Zip Code:

Home Phone: include area code	Work Phone: include area code	Ext:	E-Mail Address:
( )	( )		
Cell Phone: include area code	Fax Phone: include area code		Other Phone: include area code
( )	( )		( )

Employment Information

The following is for: ⍒ the patient
⍒ the person responsible for payment

Employer Name: Phone: include area code ( )

Address: Street: City: State: Zip Code:

Referral Information

Whom may we thank for referring you to our practice?

⍒ Another patient, friend ⍒ Another patient, relative ⍒ Yellow Pages ⍒ School
⍒ Another Dental Office ⍒ Work ⍒ Newspaper ⍒ Other _____

Name of person or office referring you to our practice: