



# WELCOME

## Patient Information

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_

Cell# \_\_\_\_\_

Email \_\_\_\_\_

Preferred Method of Contact \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Cell# \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Friend  Yellow Pages  Internet  Ad  Insurance

## Dental Insurance

Primary Insurance Co. \_\_\_\_\_

Phone# \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ ID# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Phone# \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ ID# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### IN CASE OF EMERGENCY

(Specify someone who does not live in your household.)

Name \_\_\_\_\_

Home# \_\_\_\_\_

Cell# \_\_\_\_\_

Work# \_\_\_\_\_

Relationship \_\_\_\_\_