# *Patient Information*

*Please Print*

Circle one: Dr/Mr/Mrs/Ms/Miss

First:_____Middle:_____Last:_____Jr/Sr:_____

Street:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____May we contact you by email? Circle **Yes No**

Patient Social Security Number _____-_____-_____ Patient Date of Birth ____/____/_____Sex: (Circle) **M F**

Emergency Contact:_____Phone:_____

Preferred Pharmacy_____

How did you hear about us?

Internet _____
Insurance Company
Referral
Other:_____

## Insurance Information

Do you have Dental Insurance? (circle) **Yes No**

Do you have Secondary Dental Insurance? (circle) **Yes No**

| **Primary Insured** | | **Secondary Insured** | |
|---|---|---|---|
| Subscriber Name | | Subscriber Name | |
| Subscriber SSN | | Subscriber SSN | |
| Date of Birth | | Date of Birth | |
| Relationship to Subscriber | | Relationship to Subscriber | |
| Employer Name | | Employer Name | |
| Employer Phone | | Employer Phone | |
| Insurance Company | | Insurance Company | |
| Insurance Group # | | Insurance Group # | |
| Insurance Phone # | | Insurance Phone # | |
| ***Please present your insurance card to our front desk to be photocopied*** | | | |