Patient Information

Date _____

Patient's Name_____
Last First Middle

Gender: **Male / Female** Date of Birth _____ Social Security # _____

Residence _____
Street City Zip

Marital Status**:** **Single** **Married** **Widowed** **Separated** **Divorced**

Home Phone _____Cell Phone _____Work Phone _____

Email Address _____

Preferred Contact Method: **Home Phone** **Cell Phone** **Work Phone** **Email**

Would you like to receive appointment reminder text messages? **Y** **N**

Would you to receive appointment reminder emails? **Y** **N**

How were you referred to our office? _____

Dental Insurance Information

Employer _____

Occupation _____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____

Do you have dual coverage? YES NO If yes, please fill out below:

Insured's Name _____ Insured's Social Security # _____

Insured's date of birth_____

Insurance Company _____ Group No. _____

Emergency Information

Emergency Contact Name: _____

Phone: _____