

# Confidential Patient Information

ABC

Patient's Name _____			
_____	_____	_____	_____
Last		Middle	
Address _____			
_____	_____	_____	_____
Street		Zip	
Home Phone _____		Birthdate _____	
e-mail address where you would like patient's appointments confirmed _____			



## Confidential Responsible Party Information



Name _____			
_____	_____	_____	_____
Last		Middle	
Residence _____			
_____	_____	_____	_____
Street		Zip	
Mailing Address (if different) _____			
_____	_____	_____	_____
Street		Zip	
How Long at this address _____		Home Phone _____	
Work Phone _____		_____	
Previous Address (if less than 3 yrs.) _____			
_____	_____	_____	_____
Street		Zip	
Social Security # _____		Birthdate _____	
Relationship to Patient _____		_____	
Employer _____		Occupation _____	
No. Years Employed _____		_____	
Spouse's Name _____		Relationship to Patient _____	
Employer _____		Occupation _____	
No. Years Employed _____		_____	
Social Security # _____		Birthdate _____	
Work Phone _____		_____	
Present marital status of parents/self: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Separated-child lives with: _____			
Person/persons financially responsible for this account _____			



## Insurance Information



Policy Holder's Name _____		Soc. Sec. # _____	
Policy Holder's Employer _____		Birthdate _____	
Insurance Company _____		Group No. _____	
Union Local No. _____		_____	
Insurance Co. Address _____		Insurance Co. Phone _____	
Do you have dual coverage? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, please complete below. Which is Primary Ins.?			
Policy Holder's Name _____		Soc. Sec. # _____	
Policy Holder's Employer _____		Birthdate _____	
Insurance Company _____		Group No. _____	
Union Local No. _____		_____	
Insurance Co. Address _____		Insurance Co. Phone _____	



## Emergency Information



In case of emergency, please contact _____	
Phone _____	Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained as well as the release of dental x-rays.

Signature (Parent's signature if minor) \_\_\_\_\_ Date \_\_\_\_\_