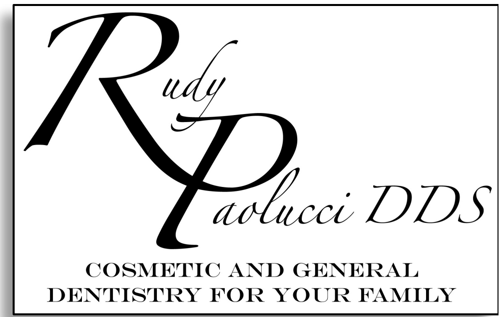
Confidential Patient Information



(Please Print Legibly)

Date: ___________________

Personal Information

Name: ____

S.S. #: _______________________________

Address: ____

City: ____ State: ______ Zip: _______________

Telephone: (Home) ___________________________ (Work) ____________________________________

(Cell) _______________________________ e-mail: ____

Birth date: _________________ Sex: _____ Marital Status: ________ Spouse Name: _______________________

Occupation: __________________________________

Referred by: __________________________________

Person Responsible for Account

Name: ____________________________________ Relationship: _________________ S.S. #: _____________________

Address: ____

City: ____ State: _______ Zip: _______________

Telephone: (Home) _____________________________ (Work) __________________________________

Dental Insurance Information

Primary Insurance Co: ____

Insurance Co. Address: ____

Employee: _________________________________ Birthdate: _________________S.S. #: _____________________

Relationship: ________________________________ Employer: ___________________________________

I.D. #: _____________________________________ Group #: ____________________________________

Secondary Insurance Co: ____

Insurance Co. Address: ____

Employee: _________________________________ Birthdate: ________________ S.S. #: ______________________

Relationship: ________________________________ Employer: ___________________________________

I.D. #: _____________________________________ Group #: ____________________________________

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

____ ______________________

Patient's Signature Date

Relationship if other than patient ____