Patient Name_______________________________________ Preferred Name_________________ Today's Date__________

Birth Date___________________ Social Security Number___________________ Sex: ◯Male ◯Female

Home Address____ City/State/Zip____________________________________

Home Phone___________________ Cell Phone___________________ E-mail______________________________________

Contact Preference: ◯Home Phone ◯Cell Phone ◯Text ◯Email ◯Work Phone Marital Status: ◯Single ◯Married ◯Divorced

Parent(s) Name(if minor) or Spouse Name_______________________ ________________ Phone__________________________

Patient or Parent's Employer____ May we contact you at work? ◯Yes ◯No

Employer Phone_________________ Address________________________________ City/State/Zip______________________

Person to Contact in case of Emergency____________________________ Phone________________ Relation_______________

What is the primary reason for your visit today? ____

Do you love your smile? ◯Yes ◯No Is there anything you would like to change? ______________________________________

Previous DDS_____________________________ Reason for Leaving____

Who may we thank for referring you? ____

Do you have a Doctor preference in our office? ____

Insurance:

Primary Insurance:

Name of Insured____ Employer______________________________________

Birth Date______________ SSN/Member ID_______________________ Insurance Company_____________________________

Secondary Insurance:

Name of Insured____ Employer______________________________________

Birth Date______________ SSN/Member ID_______________________ Insurance Company_____________________________