PATIENT INFORMATION

NAME _____ BIRTHDATE _____ AGE _____
LAST FIRST MI

ADDRESS _____ CITY _____ ZIP _____

SSN _____ DRIVERS LICENSE # _____ HOME PHONE (___) _____

EMAIL ADDRESS _____ CELL PHONE (___) _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE (___) _____

EMPLOYER ADDRESS _____ CITY _____ ZIP _____

SPOUSE _____ EMPLOYER NAME/CITY _____ WORK PHONE (___) _____

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE):

NAME _____ RELATIONSHIP _____ SSN _____ BIRTHDATE _____

ADDRESS _____ CITY _____ ZIP _____ HOME PHONE (___) _____

EMPLOYER _____ ADDRESS _____ WORK PHONE (___) _____

DRIVERS LICENSE # _____

DENTAL INSURANCE:	PRIMARY	SECONDARY
INSURED'S NAME		
RELATIONSHIP		
BIRTHDATE		
INSURED ID/SSN		
WORK PHONE		
EMPLR/GROUP NAME		
EMPLOYER ADDRESS		
EMPLOYER CITY/ZIP		
OCCUPATION		
INSURANCE CO NAME		
CLAIM ADDRESS		
CLAIM CITY/ST/ZIP		
INSURANCE CO PHONE		
GROUP #		

IF STUDENT, SCHOOL NAME/CITY _____ MIN 12 UNITS? YES NO (circle one)

I understand that I am responsible for payment of all services ***regardless*** of insurance coverage and that I must notify the office ***at least 72-hours*** in advance of any appointment change to avoid a late cancellation fee.

_____ PATIENT OR PARENT'S SIGNATURE

_____ DATE

FOR OFFICE USE ONLY: _____