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**Cosmetic, Implant and General Dentistry**

**PATIENT INFORMATION**

(Please Print)

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we much about the individual as we do about the teeth. No two people are alike. No two mouths are alike. All information, of course, will be held in strict confidence.

PATIENT INFORMATION

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Sex M F

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widow(ed) \_\_\_\_\_ Child \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ E-mail address \_\_\_\_\_

Patient's employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

Spouse's name (Parent name if minor) \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's work phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**RESPONSIBLE PARTY FOR PAYMENT (Write "Same" if it is the above patient)**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex M F

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date \_\_\_\_\_ Work phone \_\_\_\_\_

Employer \_\_\_\_\_ Employer address \_\_\_\_\_

**INSURANCE INFORMATION**

Patient's dental insurance \_\_\_\_\_ Group number \_\_\_\_\_

Employer providing insurance \_\_\_\_\_

Subscriber's name \_\_\_\_\_ Birth date \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is patient covered under another plan? Yes \_\_\_\_\_ No \_\_\_\_\_ (If Yes, please fill in next three lines.)

Patient's secondary dental insurance \_\_\_\_\_ Group number \_\_\_\_\_

Subscriber's name \_\_\_\_\_ Birth date \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer providing insurance \_\_\_\_\_

**RELATIVE WHOM WE CAN CONTACT IN EVENT OF EMERGENCY**

(Not in the same household) Name \_\_\_\_\_ Phone \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU?** \_\_\_\_\_

Please let us know if you have any fear of dental treatment so we can better help you \_\_\_\_\_

Other Comments? \_\_\_\_\_

**I VERIFY THE ABOVE INFORMATION AND GIVE MY CONSENT FOR TREATMENT**

**PATIENT'S (GUARDIAN'S) SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_