Patient Information: Today's Date:_____

Last Name:_____First Name:_____Middle Name:_____

Preferred Name:_____ Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Social Security No:_____ Gender:_____ Married:_____

Address:_____

City:_____ State:_____ Zip:_____

E-mail Address:_____

Place of Employment:_____ Work Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

If you are completing this form for another person, what is your relationship to that person? Name:_____ Relationship:_____
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

Sponsor/Parent/Guardian Information: Relationship to Patient:_____ Self:_____

Last Name:_____First Name:_____Middle Name:_____

Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Social Security No:_____ Date of Birth:_____ Employer:_____

Insurance Information:

Insurance Carrier:_____ ID Number:_____ Group Number:_____

Insurance Phone Number:_____ Insurance Address:_____

Name and Number of nearest relative not living with you:_____
How did you hear about us?_____

To the best of my knowledge, all of the answers regarding my personal and medical information are true and correct. If I ever have any changes in my health, or if any medicines change, I will inform my dentist at the next appointment.

Signature of Patient/Parent/Guardian:_____