Name: _____

Address: _____ City & Zip: _____

SS# _____ - _____ - _____ Birthday: _____ /_____ /_____ Sex: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Phone: _____ Cell: _____ Email:_____

We confirm through electronic texts prior to making phone calls. Would you like to receive text messages to confirm your appointments?

☐ **Yes** ☐ **No**

Responsible Party **(if minor):** _____ Relationship to Patient: _____

In Case of Emergency (closest relative or friend):

Name: _____ Phone: _____

Ins. Policy Holder Information:

Dental Ins. Co. _____ Policy # _____

Employer: _____

Employer Address: _____

City & Zip: _____ Phone: _____

Name of Policyholder **(if different from above)**: _____

Address: _____ City & Zip: _____

Phone: _____ E-mail: _____

SS# _____ - _____ - _____ Birthday: _____ /_____ /_____

Whom may we thank for referring you to our office? _____