PATIENT INFORMATION

Name:	Relationship to Person Responsible for Payment of Account: ☐ Self ☐ Spouse ☐ Child ☐ Non-family Member	
Address:	Home Phone #: ( ) _____ - _____ Cell Phone #: ( ) _____ - _____ Email: _____	
Employer:	Business Phone # ( ) _____ - _____ Ext _____	
Date of Birth:	Social Security #: _____ - _____ - _____	Medical Doctor's Name: Phone #: ( ) _____ - _____
Preferred Pharmacy:	**In Case of Emergency, call (name):** Relationship: Phone #: ( ) _____ - _____	

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (if not the same as above)

Name:	Address: *(if different from above)*	Home Phone #: *(if different)* ( ) _____ - _____
Employer:	Business Phone #: ( ) _____ - _____ Ext _____	Cell Phone #: ( ) _____ - _____
Date of Birth: ____ / ____ / _____	Social Security #: _____ - _____ - _____	

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER	**SECONDARY CARRIER** *(if you have dual Dental Insurance Coverage)*
Insurance Company Name:	Insurance Company Name:
Insurance Company Address:	Insurance Company Address:
Group #:	Group #:
Insurance Company Phone# ( ) _____ - _____	Insurance Company Phone# ( ) _____ - _____