PATIENT INFORMATION

Name:	Relationship to Person Responsible for Payment of Account: ❑ Self ❑ Spouse ❑ Child ❑ Non-family Member	
Address:	Home Phone #: ( ) ________-____________ Cell Phone #: ( ) ________-____________ E-mail: ________________________________	
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 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 double Dental Insurance Coverage*
Insurance Company Name:	Insurance Company Name:
Insurance Company Address:	Insurance Company Address:
Group #:	Group #:
Insurance Company Phone #: ( ) ________-____________	Insurance Company Phone #: ( ) ________-____________